GundersenOne
INDIVIDUAL POINT OF SERVICE POLICY

Gundersen Health Plan, Inc.
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601

IMPORTANT INFORMATION

Gundersen Health Plan, Inc. (also referred to as "us," "we," or "health plan,") a health maintenance organization, has entered into an agreement with you to provide you with an Individual Health - Hospital/Surgical/Medical Expense benefit plan.

This is your Policy as long as you are eligible for insurance, and you become and remain insured with us. This Policy describes the essential features of your health care benefit plan.

Participating providers are independent contractors and are not employed by us. We provide benefits for covered services under your individual health insurance policy. We do not provide health care services. We, in performing our obligations under this individual health insurance policy, are acting only as a health maintenance organization with respect to the individual health insurance policy.

The laws of the State of Iowa govern all terms, conditions and provisions of individual health insurance policy and applicable laws.

10-DAY RIGHT TO RETURN POLICY

Please read this Policy carefully. If you are not satisfied with this Policy for any reason you may, within 10 days after you receive it or have access to it electronically, whichever is earlier; return it for a full refund of the premium paid.

GUARANTEED ISSUE & RENEWABILITY

We will accept every individual that applies for coverage, as outlined in the Eligibility and Enrollment Section of this Policy. This policy is guaranteed renewable and remains in effect at the option of the Policyholder, except as provided in the When Coverage Ends section of this Policy.

The Gundersen Health Plan bases medical necessity decisions regarding coverage by consulting a variety of resources. This includes nationally developed medical policies; commercially recognized criteria sets; regionally developed medical coverage policies; and locally produced specialty medical coverage policies. Additionally, the Health Plan involves appropriate practitioners in development, adoption and review of criteria and medical coverage policies.

2016.IA.POS.INDIVIDUAL.cert
Revised: 09/22/2015
IID Disposition Date: 09/23/2015
Effective Date: 01/01/2016

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IMPORTANT TELEPHONE NUMBERS

Customer Service	(608) 775-8092 or (855) 685-6404
For people who are deaf, hard of hearing, or speech impaired	(800) 877-8973 or 711 or you may call through a video relay service company of your choice.
Free of Charge Language Assistance	(608) 775-8092 or (855)-685-6404
Nurse Advisor Line	(608) 775-4454 or (800) 858-1050
Member Advocate	(608) 775-8052 or (855) 685-6404, ext. 58052

Our normal office hours are Monday through Friday, 8:00 a.m. until 5:00 p.m. CST. If you are calling outside of our normal office hours, you can leave a confidential voice mail message. Your call will be returned on the next business day.

IMPORTANT FAX NUMBERS

Medical Management	(608) 775-8003
Member Advocate	(608) 775-8060
Pharmacy Department	(608) 775-8790

You can also visit our website at www.gundersenhealthplan.org.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Iowa Code 514A.3

Please read the copy of your Application you received when you were approved for this Policy. Carefully check the Application and write to us within 10 days if any information shown on the Application is not correct and complete. The Application is part of your contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the Application are correct and complete. This Policy is subject to rescission for two years from the effective date on the Application, should it be determined that the Member committed fraud or made material misrepresentation on their Application.

IMPORTANT NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to use the services of a non-participating provider for a covered service, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER WE HAVE PAID OUR REQUIRED PORTION.** Non-participating providers may bill enrollees for any amount up to the billed charge after we have paid our portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers, and information on out-of-pocket expenses by calling Customer Service at the telephone number located on page 5 of this Policy.

IMPORTANT NOTICE CONCERNING USUAL AND CUSTOMARY CHARGES

The methodology used in determining the usual and customary charge for non-participating provider services, supplies and durable medical equipment is as follows: We settle claims based on a specific methodology and the eligible amount of the claim, as determined by the specific methodology, which may be less than the provider's billed charge.

You may contact us before a procedure is performed to determine if the provider's estimated charge will be within the usual and customary fee. You will need to provide us with the estimated charge, the CPT or HCPCS code and the estimated date of service.

The Usual and Customary fee is defined as *the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.*

If you have questions or require language assistance, please call Customer Service at the telephone number located on page 5 of this Policy.

IMPORTANT NOTICE CONCERNING YOUR RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, we may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), in consultation with the mother, decides to discharge the mother or newborn earlier.

Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, we may impose continued stay approval for the portion of stay after the 48 or 96 hours.

GUNDERSEN HEALTH PLAN

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: SEPTEMBER 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Interpreter Services

English – For help to translate or understand this, please call (800) 897-1923 or (608) 775-8007.
For people who are deaf, hard of hearing or speech impaired, please call (800) 877-8973, TTY 711, or you may call through a video relay service company of your choice.

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono (liberte)
(800) 897-1923 or (608) 775-8007
Para las personas que son sordos, disco duros de la audiencia o intervención de personas con problemas, por favor llaman a TTY 711, o puede llamar a través de una empresa de servicio de retransmisión de video de su elección.

Russian – Если вам не всѐ понятно в этом документе, позвоните по телефону (бесплатно)
(800) 897-1923 or (608) 775-8007
Для людей, которые являются глухих, жесткий слуха или речи с дефектами зрения, пожалуйста позвоните 711 или вы можете позвонить через видео реле услуг компании по вашему выбору.

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau (dawb)
(800) 897-1923 or (608) 775-8007
Rau cov neeg lag ntseg, tsis hnov lus zoo los yog tsis paub hais lus, thov hu rau TTY 711, los yog koj siv tau ib lub tuam txhab uas siv kev yees duab video xa xov uas koj xaiv.

Interpreter services are provided free of charge to you.

We are required by law to protect the privacy of your personal and medical information. We are also required to provide you with this Notice, which explains how we obtain, use and protect your personal and medical information and when we can give out or

"disclose" that information to others. You also have rights regarding your personal and medical information that are described in this Notice.
Gundersen Health Plan maintains physical, electronic and procedural safeguards that comply with federal and state regulations to protect your non-public personal information. We limit the use of oral, written, and electronic information about you and ensure that only authorized staff, with a job related need to know, have access to it. We maintain these safeguards and review them regularly to protect your privacy.

The terms "personal information" or "medical information" in this Notice include any non-public personal information, in any form, that is created or received by Gundersen Health Plan. "Medical information" relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

If you have questions about any part of this Notice, complaints regarding our privacy practices, or would like more information about our privacy practices, please contact us at the following address, or call our Customer Service Department at (800) 897-1923. For people who are deaf, hard of hearing or speech impaired, please call (800) 877-8973, TTY 711, or you may call through a video relay service company of your choice.

Gundersen Health Plan
Kelly Skifton, Privacy Officer
1900 South Avenue, NCA2-01
La Crosse, WI 54601
(608) 775-8758
knskifto@gundersenhealth.org

How We May Use or Disclose your Health Information

The following categories describe the ways that Gundersen Health Plan may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Payment Functions. We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. Health information may be shared with other government programs such as Medicare, Medicaid, or private insurance to manage your benefits and payments. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

Health Care Operations. We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may

include underwriting, premium rating and other activities relating to plan coverage, conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

Treatment. We may use or disclose your health information to a physician or other health care provider for treatment, provide information on health related programs such as alternative medical treatments, or health related products and services.

To Business Associates. We may share your information with third party "business associates" that perform various activities for Gundersen Health Plan, for example services related to claims processing, collections, or mailing of information to our members. Whenever an arrangement between Gundersen Health Plan and a business associate involves the use or disclosure of your personal or medical information, we will have a written contract that contains terms to protect the privacy of your information.

Disclosures to Plan Sponsors. We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.

Required by Law. As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Public Health. Information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Public Safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security. We may disclose your health information for military, prisoner, and national security.

Workers' Compensation. We may disclose your health information as necessary to comply with worker's compensation or similar laws.

Marketing. We may contact you to give you information about health-related benefits and services that may be of interest to you. If we receive compensation from a third party for providing you with information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this third party.

Fundraising. We may contact you for fundraising purposes at which time you may opt out from receiving these communications. Use or disclosure for fundraising purposes is limited to information related to demographics (including your contact information), dates of service, and health insurance status.

Research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

National Security. We may use or disclose health information relating to military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

When Gundersen Health Plan May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Gundersen Health Plan will not use or disclose your personal or medical information without your written authorization from you. If you do authorize us to use or disclose your personal or medical information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

- Your authorization is necessary for most uses and disclosures of psychotherapy notes.
- Your authorization is necessary for any disclosure of health information in which the health plan receives compensation.

Genetic Information and Underwriting Activities: Gundersen Health Plan is prohibited from using or disclosing genetic information for underwriting purposes,

including determination of benefit eligibility. If we obtain any health information for underwriting purposes and the policy or contract of health insurance or health benefits is not written with us or not issued by us, we will not use or disclose that health information for any other purpose, except as required by law.

Applicability of More Stringent State Law: Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws that are more stringent than Federal laws, including disclosures related to mental health and substance abuse, developmental disability, alcohol and other drug abuse (AODA), and HIV testing.

Your Rights Regarding Protected Health Information About You

- **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your personal and medical information. Gundersen Health Plan is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to Gundersen Health Plan Privacy Officer at 1900 South Avenue, NCA2-01, La Crosse, WI 54601

- **Right to Request Confidential Communications.** You have the right to receive your health information through a reasonable or alternative means or at an alternative location. For example, you may ask that we only communicate with you at a certain phone number or address. If you wish to request confidential communications, you must submit your request in writing to Gundersen Health Plan Privacy Office at 1900 South Avenue, NCA2-01, La Crosse, WI 54601.

- **Right to Inspect and Copy.** You have the right to inspect and receive an electronic or paper copy of health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to Gundersen Health Plan Privacy Officer at 1900 South Avenue, NCA2-01, La Crosse, WI 54601. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

- **Right to Request Amendment.** You have the right to request that Gundersen Health Plan amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to Gundersen Health Plan Privacy Officer, 1900 South Avenue, NCA2-01, La Crosse, WI 54601. You must provide a reason for your request.

- **Right to an Accounting of Disclosures**. You have the right to receive a list or "accounting of disclosures" of your health information made by us in the past six years. To request an accounting of disclosures, you must submit your request in writing to Gundersen Health Plan Privacy Officer at 1900 South Avenue, NCA2-01, La Crosse, WI 54601. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the cost of providing the lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. This will not include disclosures made for the purpose of treatment, payment, or health care operations.

- **Right to a Paper Copy.** Upon request, even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. You may print a copy of this Notice and future amendments to it by accessing the Gundersen Health Plan website, www.gundersenhealthplan.org, or by sending your written request to Gundersen Health Plan Privacy Officer, 1900 South Avenue, NCA2-01, La Crosse, WI 54601.

- **Right to be Notified of a Breach.** You will be notified in the event of a breach of your unsecured protected health information. Gundersen Health Plan is required by law to maintain the privacy practices with respect to the health information and provide you with notice of its legal duties and privacy practices with respect to health information.

Changes to this Notice and Distribution

Gundersen Health Plan reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains.

As your health plan, we will provide a copy of our notice upon your enrollment to the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. (If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you.) The notice is provided to the named insured/subscriber/primary insured of the plan and will pertain to the insured and dependents named under this insured.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed, as well as the rights you have to your health information. Gundersen Health Plan is required to abide by the terms of its then-current Notice. If our Notice has a material change, we will post information regarding this change to the website at www.gundersenhealthplan.org, for you to review. In addition, following the date of the material change, we will include a

description of the change that occurred and information on how to obtain a copy of the revised Notice in our annual mailing to all individuals then covered by the plan.

Complaints. Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to Gundersen Health Plan Privacy Officer, 1900 South Avenue, NCA2-01, La Crosse, WI 54601. Gundersen Health Plan will not retaliate against you in any way for filing a complaint. All complaints to Gundersen Health Plan must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services at http://www.hhs.gov/ocr/privacy/hipaa/complaints/ or call (800) 368-1019.

FINANCIAL INFORMATION PRIVACY NOTICE

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this Notice, "personal financial information" means information, other than medical information, about insured member or prospective member applying for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms such as name, address, age, and social security number, and

- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our members or former members to any third party, except as required or permitted by law. We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administrating your health care coverage or providing services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal financial information.

We may disclose personal financial information to financial institutions which perform services for us, such as electronic fund transfer for payment of premiums.

PLAN DESCRIPTION INFORMATION

This is an individual health benefit plan. Benefits are provided under a Contract entered into between you and us. Claims for benefits are sent to us, and we are responsible for paying claims covered under this Policy. You pay insurance premiums to us for yourself and your covered dependents.

This Policy contains information regarding eligibility requirements, termination provisions, premium payment requirements, a description of the benefits provided, and other general plan information.

In addition to this Policy, please refer to your Summary of Benefits and Coverage (SBC) and Schedule of Benefits (SOB) for specific coverage and cost sharing information. Individual and family deductibles are shown on the Summary of Benefits and Coverage document.

- If you have family coverage and are enrolled in a qualified high deductible health plan (HDHP) with a Health Savings Account (HSA), you may have an aggregate deductible. Aggregate deductible is defined as *the entire family annual deductible must be met before the plan pays benefits.* Cost sharing limits for individuals on family plans are listed on the SBC.

- If you have family coverage and are enrolled in a plan that is not an HSA qualified high deductible plan, you have an embedded deductible. Embedded deductible is defined as *each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before the plan pays benefits.*

The purpose of this Policy is to set forth the provisions of this plan that provides for the payment or reimbursement of all or a portion of eligible medical services incurred.

PLAN NAME: Gundersen Health Plan, Inc., Individual Policy

TYPE OF PLAN: Individual Health - Hospital/Surgical/Medical Expense

CLAIMS ADMINISTRATOR: Gundersen Health Plan, Inc.
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601
(608) 775-8092 or (855) 685-6404
711, (800) 877-8973 or you may call through a video relay service company of your choice.

SECTION 1 – INTRODUCTION

INTRODUCTION

This Policy has been prepared by us to help explain your coverage. Please refer to this document whenever you require medical services. It describes how to access medical care, what health services are covered by us, and what portion of the health care costs you will be required to pay. Many words used in this document have special meanings and are defined (in italics) for you.

This Policy, the Application, your Summary of Benefits and Coverage, your Schedule of Benefits and any amendments attached shall constitute the entire contract under which covered services and supplies are provided by us.

This Policy also contains Exclusions (Section 5), so please read this Policy carefully.

If you have questions, require language assistance, or need to have your member materials provided in another format (at no cost to you) please call the Customer Service telephone number located on page 5 of this Policy. For people who are deaf, hard of hearing, or speech impaired please call (800) 877-8973, TTY 711, or you may call through a video relay service company of your choice. Interpreter services and assistance with plan information are provided free of charge to you. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. If you are calling outside of our normal office hours, you can leave a confidential voice mail message and your call will be returned on the next business day. You can also visit our website at www.gundersenhealthplan.org.

If you would like to meet with a customer service representative in person, you can visit us during our normal office hours. Our offices are located at 3190 Gundersen Drive, Onalaska, Wisconsin. We are also at the Resource Center located in the Gundersen Clinic located at 1836 South Avenue, La Crosse, Wisconsin.

SECTION 2 – ACCESS TO HEALTH CARE

Our goal is to provide coverage for medically necessary covered services for you and your dependents. At the same time, we want to ensure that care is sought when and where it is most appropriate. When obtaining treatment, please present your health plan ID card. We will then be billed directly, and we will notify you of any charges for which you are responsible.

PARTICIPATING PROVIDER NETWORK

The definition of participating provider is *a physician, participating practitioner, qualified treatment facility, pharmacy, hospital, clinic or other healthcare provider which has entered into a participating provider contract with us to provide medical treatment, services or supplies in our provider network, who is listed in the Provider Directory; and from which a member may seek services without a written referral.*

In addition to both primary and specialty care, the network of participating providers includes other health care providers such as pediatric nurse practitioners, nurse midwives, occupational and physical therapists, and behavioral health service providers such as psychiatrists, clinical psychologists, and social workers. The network of participating providers also includes chiropractors, durable medical equipment providers, hospice, home health care, and pharmacy providers.

Participating providers are listed in our Provider Directory. Included in the Provider Directory are the addresses, office hours, and phone numbers of participating providers. The participation status of providers may change from time-to-time, or may not apply at certain locations. Please call Customer Service at the telephone number provided on page 5 of this Policy to verify the participation status of the provider. You also can see our Provider Directory on our web site at www.gundersenhealthplan.org.

You may seek services of a specialist directly without obtaining prior approval through a written referral as long as you seek care from a participating provider.

IN-NETWORK VERSUS OUT-OF-NETWORK LEVELS OF BENEFITS

This Policy provides two levels of benefits, Level 1 and Level 2, as described below.

LEVEL 1: IN-NETWORK (PARTICIPATING PROVIDER)
This Policy provides in-network benefits whenever you obtain health care services from a participating provider or with an approved written referral to a non-participating provider. Referrals will only be authorized when services do not exist through our

network of contracted providers. A referral must be approved by our Medical Director prior to services being provided. In-network benefits are described in the In-Network column of the Summary of Benefits and Coverage and Schedule of Benefits. These benefits are also called Level 1 benefits.

The definition of a Medical Director is *a physician employed by us to evaluate and approve the delivery of appropriate medical care in a cost-effective manner while maintaining the highest quality of care possible.*

LEVEL 2: OUT-OF-NETWORK (NON-PARTICIPATING PROVIDER)
This Policy provides out-of-network benefits if you choose to use a non-participating provider. The definition of a Non-Participating Provider is *a physician or other health care provider who has not signed a participating provider contract with us to provide medical treatment, services or supplies to members.*

You may choose to use a non-participating provider; however, you should always request a written referral from our Medical Director prior to receiving such services. When receiving services from a non-participating provider you will pay more out of pocket costs. For instance, a higher annual deductible and greater coinsurance will be imposed on you. The plan's payment for covered services is based on the allowed amount. Because out-of-network providers are not contracted with us, they may bill you the difference between the allowed amount and the actual charge. This amount may be significant and is your responsibility. Coverage for out-of-network benefits is described in the Summary of Benefits and Coverage and Schedule of Benefits. These benefits are also called Level 2 benefits.

PRIOR AUTHORIZATION

We do recognize that your physician has the sole responsibility for making the medical decisions regarding your care. However, in order to monitor the frequency, intensity and appropriateness of the services rendered to you, we require prior authorization for certain services. The prior authorization process determines both benefit determinations and medical necessity (see definition below). Services that require a prior authorization are identified in your Summary of Benefits and Coverage (SBC), your Schedule of Benefits and this Policy.

Medical prior authorization activities are conducted by our Medical Management Department. Failure to obtain necessary prior authorization may result in a denial of coverage, in which case the responsibility of payment may be yours. Please read this Policy, your Summary of Benefits and Coverage and your Schedule of Benefits carefully to see what covered services require a prior authorization. It is recommended that you contact us for prior authorization requirements before you receive care. Please call Customer Service at the telephone number located on page 5 of this Policy.

Drug prior authorization activities and exception requests are conducted by our Pharmacy Department. Certain prescription drugs require prior authorization and non-formulary drugs would require an exception for coverage under essential health benefits. Failure to obtain the necessary approval may result in a denial of coverage for medications. Please refer to Section 4, Prescription Drugs, of this Policy to review covered, non-covered, and exception processes for pharmacy services. Due to periodic changes of the prescription drug prior authorization list, it is recommended that you refer to our searchable formulary on the plan's website at www.gundersenhealthplan.org/formulary to review the most current information.

The definition of Medical Necessity/Medically Necessary is *medical treatment, services or supplies that are required to identify or treat a sickness or injury and which, as determined by us, are:*

1. *Consistent with the symptoms, the diagnosis or the treatment of your medical condition;*
2. *Appropriate with regard to the standards of good medical practice;*
3. *Not primarily for the convenience of you or your immediate family, or that of your physician or another provider;*
4. *The most appropriate and cost-effective level of medical service or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided to you as an outpatient;*
5. *Of proven value or usefulness; and*
6. *Compliant with your provider's treatment plan.*

The fact that a physician, a participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

OBTAINING PRIOR AUTHORIZATION

You may obtain written prior authorization by contacting your provider. The provider may submit a written prior authorization request to us for review before any recommended treatment, services, prescription medication/drugs, devices and/or supplies are obtained.

Prior authorization requests for medical services must be sent to us at the address listed below.

Gundersen Health Plan, Inc.
Medical Management Department
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601
Fax: (608) 775-8003

Prior authorization requests or exception requests for prescription coverage must be sent to us at the address listed below.

Gundersen Health Plan, Inc.
Pharmacy Department
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601
Fax: (608) 775-8790

For standard determinations, you will be notified of the decision no later than 10 business days after our receipt of a request. If it is determined by us the request fails to follow our procedures for filing a prior authorization, you will be notified within five days. The period of the initial decision may be extended up to an additional 15 calendar days if we determine it is necessary due to: 1) such matters beyond our control (including a failure to submit necessary information), and 2) we notify you to explain the circumstances regarding an extension prior to the expiration of the initial 10 business days.

If the request is expedited, you will be notified of the decision within 72 hours of receipt of the documentation supporting that exigent circumstances exist.

Prior authorized services are subject to benefit limitations and eligibility. Prior authorization requirements apply whether we are your primary or secondary payer of benefits.

REFERRAL PRIOR AUTHORIZATIONS USING LEVEL 1 BENEFITS

Referrals are required for any services outside of our provider network to use Level 1 Benefits. If your participating provider feels that you require specialty care beyond that available from other participating providers, then they may submit a referral form to request services from a non-participating provider. The definition of a referral form is *the form prepared in writing by a participating provider for you in order for you to receive coverage for medical treatment, services, or supplies from a non-participating provider. Medical care, treatment, services or supplies that are received through a referral are subject to the exclusions and limitations of this Policy. Referrals must be submitted and approved in writing by our Medical Director before any recommended treatment, services or supplies are obtained for a covered expense.* The definition of non-participating provider is *a physician or other health care provider who has not signed a participating provider contract with us to provide medical treatment, services or supplies to members.* Referrals are not valid without our Medical Director's approval.

Referrals for out-of-network services will not be granted/approved when capability exists for a particular expertise or service within our participating provider network.

You will be notified in writing of the decision. If it is approved, the referral form will state the provider, the type or the extent of treatment being authorized, the number of visits, and the period of time during which the referral is valid. Eligible services without an approved referral will be paid at your Level 2 benefits. Take a copy of the approved written referral with you when you receive the services.

STANDING REFERRALS TO A NON-PARTICIPATING SPECIALTY PROVIDER
You may request that your participating provider generate a written standing referral to a non-participating specialty provider if that type of specialty provider is not available in our provider network. Approved standing referrals to a non-participating specialty provider need to be renewed each year. Specific examples of such specialty providers include:

1. Transplant physicians and surgeons
2. Specialists in major burn care

Referral authorization services are subject to certain benefit limitations and eligibility. The referral requirements apply whether we are your primary or secondary payer of benefits.

EMERGENCY CARE

An emergency is defined as *a medical condition involving acute symptoms of sufficient severity that a person would reasonably expect to conclude that a lack of immediate medical attention would result in serious jeopardy to the person's health, impairment to bodily functions or serious dysfunction to one or more organs.*

In case of an emergency medical condition, you should seek care from the nearest provider of health care that is equipped to handle your condition. If you are admitted to a hospital following an emergency medical condition, please contact us within 48 hours of the admission or as soon as it is reasonably possible. Follow-up care out-of-network will be paid at your Level 2 benefits. Please contact Customer Service at the telephone number provided on page 5 of this Policy. See Section 4 for the definition and coverage guidelines of the urgent care services.

NEW TECHNOLOGY

We frequently evaluate new technology for inclusion as a covered service. In order to cover the services that utilize new technology, all the following criteria must be met:

1. The new technology must be non-experimental/non-investigational;
2. It must be approved by the appropriate regulatory body;
3. The research and review of evidence-based medicine demonstrates that the new technology has a positive effect on health and is safe; and
4. It is more beneficial or less expensive than current alternative treatments.

If an evaluation is performed due to a request for coverage from your provider, a decision shall be made within five working days after all the necessary information needed to make the decision has been received. If coverage is denied, the criteria for the denial will be communicated to the party requesting the evaluation. An explanation of the grievance process will also be issued.

NURSE ADVISOR PROGRAM

A Nurse Advisor Program is available to you (at no charge) 24 hours a day, and 365 days a year. You may call them to get advice on whether to go to an emergency room, to see your physician, or to use other health services. A nurse is available at all times, supported by Gundersen physicians. When a health problem arises, you will have access to advice from a health professional. To use this service, call the Nurse Advisor at the telephone number provided on page 5 of this Policy.

CONTINUITY OF CARE OF A TERMINAL ILLNESS
(Iowa Code 514C.17)

If we terminate our contract with a participating health care provider while you are undergoing a specified course of treatment for a terminal illness or a related condition, then you may continue to receive treatment from that provider for the terminal illness or related condition, for a period of up to ninety (90) days.

SECTION 3– ELIGIBILITY AND EFFECTIVE DATES

PREMIUMS, GRACE PERIOD, AND RENEWAL PERIOD PROVISIONS

PREMIUMS

Your initial premium payment is due prior to the effective date of your policy. Subsequent premium payments are due before the first day of the month prior to coverage.

Your premium rate will be based on the following factors:

1. Single or family coverage;
2. Your age and the age of each covered dependent; and
3. Your geographic rating area.

Your premium may be adjusted accordingly during the policy year if you add or remove dependents, if you relocate, or if you elect to change your benefit plan. If coverage is obtained through the Health Insurance Marketplace, premiums may also be adjusted due to changes in the Advanced Premium Tax Credit.

GRACE PERIODS

Your initial first month's premium payment is due before the effective date of your policy. If your initial first month's premium payment is not received within this timeframe, your coverage will be cancelled.

Subsequent premium payments are due before the first day of the month prior to coverage. You have a three-month grace period in which to make your premium payment. Your grace period begins on the premium due date and extends three months from that date. If premiums remain unpaid during the three-month grace period, your coverage will end on the last day of the first month of your grace period. During the grace period you must pay the full outstanding premium for coverage to remain in force.

If you exhaust your three-month grace period and your coverage is terminated due to nonpayment of premium:

- You will be responsible for your premium payment for the first month of coverage during your grace period.

- You will be responsible for any claims incurred beyond the first month grace period.

- You will be unable to enroll in another Qualified Health Plan under a Special Enrollment Provision.

RENEWAL PERIODS
Your policy will renew annually on January 1 and may be subject to premium changes due to:

- Benefit changes,
- A new rate table applies,
- Your age and the age of each covered dependent, and
- Your geographic rating area.

We will provide written notice of a renewal premium rate change at least 30 days before any such change takes effect for this Policy. If the renewal premium rate is increased by 25% or more for a renewal period, we will provide a written notice at least 60 days before any change takes effect. The renewal premium rate change takes effect on the first day of the renewal period as described in the renewal notice.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY
Gundersen Health Plan does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

You may enroll for coverage by submitting a completed Application and the appropriate premium. You will not be covered by this Policy until your effective date and your first month's premium is received. The effective date is defined as the date on which you become enrolled and entitled to the benefits specified in your Summary of Benefits and Coverage.

To be eligible to enroll you must:

1. Live, work, or reside in the Gundersen Service Area;
2. Be a citizen of the United States;
3. Not be incarcerated.

Eligibility of Dependents
An eligible dependent is:

1. A legally recognized spouse;

2. A married or unmarried child that is a;
    a. Natural child,
    b. Legally adopted child,
    c. Child placed with you for the purpose of adoption,
    d. Stepchild, or
    e. Child for whom you have legal guardianship.

We will not deny eligibility for your child, or we will not set a premium rate for your child based on financial dependency, residency with a parent, residency outside of the service area, whether or not you claim the child as a tax exemption, marital status, or based on the fact that your child is employed or otherwise eligible to enroll in other employer-sponsored health plan coverage.

Annual Open Enrollment Period
The Annual Open Enrollment Period begins November 1 and runs through January 31.
1. Applications received on or before December 15 will be effective January 1.
2. Applications received December 16 through January 15 will be effective February 1.
3. Applications received January 16 through January 31 will be effective March 1.

Special Election Period
1. Adoption or Placement for Adoption
    a. We must receive your application within 60 days from the adoption or placement,
    b. Your effective date can be:
        i. The date that a court makes a final order granting adoption of the child or on the date that the child is placed for adoption, or
        ii. If you choose and your application is received between the 1st and 15th of the month, the coverage effective date can be the first date of the following month, or
        iii. If your application is received between the 16th and last day of the month, the coverage effective date can be the first day of the second following month.
2. Birth
    a. We must receive your application within 60 days from the date of birth,
    b. Your effective date can be:
        i. The date of birth, or
        ii. If you choose and your application is received between the 1st and 15th of the month, the coverage effective date can be the first of the following month, or
        iii. If your application is received between the 16th and last day of the month, the coverage effective date can be the first day of the second following month.

3. Permanent Move
    a. We must receive your application within 60 days from the date of the permanent move,
    b. Your effective date can be:
        i. If the enrollment is received on or before the date of the move, coverage is effective on the first of the month after the move,
        ii. If the enrollment is received after the date of the move, between the 1st and 15th of the month, the coverage effective date is the first day of the following month,
        iii. If the enrollment is received after the date of the move, between the 16th and 31st of the month, the coverage effective date is the first day of the second following month.
4. Court Orders for Dependent Children
    a. Your effective date can be:
        i. The first day of the court order, or
        ii. If you choose and your application is received on or after the date of the court order, between the 1st and 15th of the month, the coverage effective date can be the first day of the following month, or
        iii. If your application is received after the date of the court order, between the 16th and 31st of the month, the coverage effective date can be the first day of the second following month.
5. Gaining Citizenship
    a. We must receive your application within 60 days from the event,
    b. Your effective date can be:
        i. If the enrollment is received between the 1st and 15th of the month, the coverage effective date can be the first of the following month,
        ii. If the enrollment is received between the 16th and the 31st of the month, the coverage effective date can be the first of the second following month.
6. APTC (Subsidy) Change
    a. We must receive your application within 60 days from the event,
    b. Your effective date can be:
        i. If the enrollment is received between the 1st and the 15th of the month, the coverage effective date can be the first of the following month,
        ii. If the enrollment is received between the 16th and the 31st of the month, the coverage effective date can be the first of the second following month.
7. Native American
    a. You may enroll for coverage or change from one plan to another one time per month,
    b. Your effective date can be:
        i. If the enrollment is received between the 1st and 15th of the month, the coverage effective date can be the first of the following month,

        ii. If the enrollment is received between the 16th and the 31st of the month, the coverage effective date can be the first of the second following month.

8. Death
    a. Surviving members enrolled for coverage have a Special Election Period in the case of a loss of a dependent or dependent status through death,
    b. We must receive your application within 60 days from the event,
    c. Your effective date can be:
        i. The first day of the month following receipt of the application,
        ii. If the enrollment is received between the 1st and 15th of the month, the coverage effective date can be the first of the following month,
        iii. If the enrollment is received between the 16th and the 31st of the month, the coverage effective date can be the first of the second following month.
9. Marriage
    a. We must receive your application within 60 days of your marriage,
    b. Your effective date will be the first of the month following receipt of the application,
10. Divorce or Legal Separation
    a. Loss of a dependent or dependent status through divorce or legal separation,
    b. Marketplace only, as approved and determined by the Marketplace.
11. Involuntary Loss of Minimal Essential Coverage (including Medicaid or CHIP)
    a. We must receive your application within 60 days prior to or within 60 days after the loss of coverage,
    b. Your effective date will be the first of the month following receipt of the application.
12. Non Calendar Year Plans
    a. We must receive your application within 60 days from when your non-calendar year plan ended,
    b. Your effective date will be:
        i. If the enrollment is received between the 1st and 15th of the month, the coverage effective date will be the first of the following month,
        ii. If the enrollment is received between the 16th and the 31st of the month, the coverage effective date will be the first of the second following month.
13. Other Error or Misrepresentation
    a. If your enrollment is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation or inaction of an office, employee, or agent of the Marketplace, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction.

14. Violation of Material Provision
    a. If you adequately demonstrate to the Marketplace that the plan in which you are enrolled in substantially violated a material provision of its contract in relation to your enrollment.
15. Exceptional Circumstances
    a. If you demonstrate to the Marketplace, in accordance with the guidelines issued, that you meet other exceptional circumstances in the Marketplace.

WHEN COVERAGE ENDS

1. If you have not paid your full premium due by the end of the grace period, coverage will terminate on the last day of the first month of the 3 month grace period.
2. If you or a covered person commit fraud, make an intentional material misrepresentation, or permit someone else to use your identification card, as determined by Us, coverage will terminate on the last day of the month in which the event occurred.
3. If you or a covered person fails to comply with the provisions of this Policy, as determined by Us, coverage will terminate on the last day of the month in which the event occurred.
4. If you or a covered person dies, coverage will terminate on the date of death. If the covered person is the subscriber, coverage will terminate for everyone covered under the policy on the date of death.
5. If you or a covered person enters the armed forces, coverage will terminate on the last day of the month in which the event occurred.
6. If you move or reside outside of the service area, coverage will terminate on the last day of the month in which the event occurred.
7. If you change Qualified Health Plans during the annual open enrollment period or a special enrollment period, coverage will terminate on the last day of the month prior to the effective date of the change in the new Qualified Health Plan.
8. Coverage for your dependent child (including dependent children covered under a legal guardianship) will terminate on the last day of the month of their 26th birthday. or
9. Coverage for your spouse and your spouse's children will terminate on the last day of the month in which the divorce or annulment occurred.
10. Coverage termination based on receipt of your written request:
    a. If the notice is received 14 days prior to the date of termination, coverage will terminate on the date requested.
    b. If the notice is not received 14 days prior to the date of termination, coverage will terminate 14 days after the termination notice is received or the end of the current month, whichever comes first.

11. If you or a covered person becomes eligible for Medicaid, CHIP or other federal or state funded programs, coverage will terminate on the last day before such other coverage becomes effective.
12. Coverage terminates on the date this Policy terminates, coverage is rescinded, or Gundersen Health Plan is no longer a Qualified Health Plan.

If coverage is terminated by the issuer, 30 days prior notice will be provided and will include the reason for termination.

It is your responsibility to report any eligibility changes to us and to the Health Insurance Marketplace, if coverage is obtained through the Marketplace, within 30 days of the change.

EXTENSION OF COVERAGE FOR CHILDREN

PHYSICAL OR MENTAL IMPAIRMENT

Children who are currently covered under this Policy, who are, or become, incapable of self-support due to a physical or mental impairment, continue to be eligible after attainment of the limiting age if the child is:

1. Unmarried;
2. Dependent on you for support and maintenance; and
3. Incapable of self-sustaining employment.

A physical or mental impairment is defined as *an impairment that substantially limits one or more of the major life activities of a person.* Physical impairments include a physical disorder or condition, a cosmetic disfigurement or an anatomical loss affecting one or more of the following body systems:

1. Neurological;
2. Musculoskeletal;
3. Special sense organs, including speech organs;
4. Respiratory;
5. Cardiovascular;
6. Reproductive;
7. Digestive;
8. Genitourinary;
9. Hemic and lymphatic;
10. Skin; or
11. Endocrine.

Coverage may be continued as long as you remain insured under this Policy, your child remains unmarried, incapacitated and dependent upon you. You must provide us with

written proof of incapacity within 30 days after the child's attainment of the limiting age. Dependency proof will be verified by submitting a copy of your annual tax return that lists this child as a dependent. Annually, or at reasonable intervals during the first two years of the continued coverage, we may request that a participating provider examine your child. You must notify us immediately of a cessation of incapacity or dependency.

TERMINATION OF POLICY

We may discontinue offering this Policy in the state of Iowa if all of the following apply:

1. We must provide notice to all affected members and to the Commissioner in each state in which an affected member resides no later than 180 days before termination of coverage;
2. We must provide notice of the discontinuance to each member covered under the plan, at least 90 days before the date on which the coverage will be discontinued;
3. We will offer to each member to whom we provide coverage of this type in the state of Iowa the option to purchase our other plans that we offer in the service area; and
4. We do not establish a new class of business earlier than five years after the nonrenewal of the policies.

SECTION 4 – BENEFITS: COVERED AND NON-COVERED SERVICES

If you are unsure if a service will be covered, please call Customer Service at the telephone number located on page 5 of this Policy prior to having the service performed.

Medical services, supplies or treatment are all covered expenses when they are: 1) incurred while your coverage is in force; 2) received from a participating provider; 3) received from a non-participating provider (including in an emergency); 4) listed as a covered expense under this COC; 5) not in excess of any maximum amount payable under this COC; 6) consistent with your Summary of Benefits and Coverage and Schedule of Benefits; and 7) medically necessary. Medically Necessary is defined as *medical treatment, services or supplies that are required to identify or treat an illness or injury and which, as determined by us, are:*

1. *Consistent with the symptoms, the diagnosis or the treatment of your medical condition;*
2. *Appropriate with regard to the standards of good medical practice;*
3. *Not primarily for your convenience, or your immediate family, or that of your physician or another provider;*
4. *The most appropriate and cost-effective level of medical service or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or the conditions require that the medical services or supplies cannot be safely provided as an outpatient;*
5. *Of proven value or usefulness; and*
6. *Compliant with your provider's treatment plan.*

Please refer to Section 2 of this COC, as well as your Summary of Benefits and Coverage and Schedule of Benefits for a list of services that require prior authorization. Because we may periodically add, remove, or change the prior authorization list, it is recommended that you contact us for prior authorization for the services listed. Please call Customer Service at the telephone number provided on page 5 of this COC.

The fact that a physician, a participating provider, or any other provider, has prescribed, ordered, recommended, or approved a treatment, a service or supply, or has informed you of its availability, does not make a covered service medically necessary.

The coverage period is defined as the 12-month policy year for Policy renewal. The coverage period for this Policy begins on January 1. Some changes in your coverage of services may be introduced on your renewal date. Regulatory changes

required by federal or state law are introduced at any time during the coverage period.

Benefit year is defined as a 12-month period of health insurance coverage used for calculating deductibles, coinsurance, benefit limitations, and out of pocket maximums. The benefit year for this Policy is the same as a calendar year starting over each January 1. Please refer to your Summary of Benefits and Coverage and Schedule of Benefits. Claims are processed in the order received and not necessarily in the order that care is provided.

In addition to this Policy, please refer to your Summary of Benefits and Coverage (SBC) and Schedule of Benefits (SOB) for specific coverage and cost sharing information. Individual and family deductibles are shown on the Summary of Benefits and Coverage document.

- If you have family coverage and are enrolled in a qualified high deductible health plan (HDHP) with a Health Savings Account (HSA), you have an aggregate deductible. Aggregate deductible is defined as *the entire family annual deductible must be met before the plan pays benefits.*

- If you have family coverage and are enrolled in a plan that is not an HSA qualified high deductible plan, you have an embedded deductible. Embedded deductible is defined as *each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before the plan pays benefits.*

Deductible and coinsurance accumulations during the last three (3) months of the benefit period do not carry over as credits to meet your deductible for the following year.

If you are an inpatient in a covered facility on December 31, then your benefit calculations and payment obligations for the services received will start over as of January 1. Benefit calculations and payments will be based on the benefit plan in force on the day you receive your services.

COPAYMENT, COINSURANCE, AND DEDUCTIBLES

All covered services are subject to the copayment, coinsurance, and/or deductible limits shown in your Summary of Benefits and Coverage and Schedule of Benefits. The level of copayments, coinsurance and/or deductible limits that will apply to charges for covered services depends on whether you use a participating provider or a non-participating provider, and whether you obtain a referral or prior authorization.

REDUCED COST-SHARING IN THE MARKEPLACE

Cost sharing reduction is a discount that lowers the amount an individual has to pay for deductibles, coinsurance, and copayments. You may be eligible for this reduction if your have health insurance through the Marketplace, your income is below a certain level, and you choose a plan from the Silver plan category. If you are a member of a federally recognized tribe, you may also qualify for additional cost-sharing benefits. If you are eligible for cost share reduction, the Marketplace will notify us of the reduced cost-sharing.

USUAL AND CUSTOMARY CHARGES

Out-of-network benefits (Level 2) will be subject to our usual and customary charge. See the Important Notice Concerning Usual and Customary Charges that is included in this COC. The difference between the usual and customary charge and the provider's billed charge will be your responsibility. This difference does not apply toward your deductible or out-of-pocket maximum.

The Usual and Customary fee is defined as *the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.*

You may contact us before a procedure is performed to determine if the provider's estimated charge will be within the usual and customary allowance. You will need to provide us with the provider name, location and zip code of the provider, the estimated charge, the procedure code (CPT or HCPCS) and the estimated date of service.

ALLERGY SERVICES

Covered Services
1. Initial diagnostic evaluation and standard allergy testing; and
2. Allergy injections.

Non-Covered Services
1. Sublingual drops; and
2. Repeated intradermal testing or testing which is considered experimental by us, including cytotoxin testing.

AMBULANCE SERVICES

Covered Services

1. Emergently needed transportation by a professionally licensed ground or air ambulance service to the nearest hospital equipped to adequately treat your condition; and
2. Non-emergency ambulance transportation only when associated with covered hospice care.

AUTISM (IA Code – Reference 514C.28)

Autism Spectrum Disorder (ASD) services for children under the age of 21. ASD includes Autism Disorder, Asperger's Syndrome, and pervasive developmental disorder not otherwise specified. Diagnosis must be established through a comprehensive evaluation by an appropriate provider with evidence that meets criteria for a diagnosis of ASD as outlined in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Covered with Prior Authorization

Coverage for treatment of autism spectrum disorders with 20 hours per week of clinical therapeutic intervention, including but not limited to applied behavioral analysis will be managed through common methods including the use of preferred providers, utilization review, and common methods to assure services are medically necessary and clinically appropriate.

Non-Covered Services

1. Acupuncture
2. Animal-based therapy including hypnotherapy
3. Auditory integration training
4. Chelation therapy
5. Child care fees
6. Cranial sacral therapy
7. Custodial or respite care
8. Hyperbaric oxygen therapy
9. Special Diets or supplements
10. Child alarms or locators
11. Hair analysis

BARIATRIC SURGERY

Covered with Prior Authorization

1. Health Plan Medical Policy criteria must be met.
2. If approved, coverage is limited to one surgical procedure per lifetime.

BIOFEEDBACK

Covered Services

1. Coverage is limited to six treatments per benefit year for headaches, muscle wasting, and torticollis (spastic or spasmodic).

Non-Covered Services

1. Biofeedback training for urinary or stress incontinence, muscle spasm, muscle weakness or any other condition not listed as covered.

CANCER TREATMENT

Covered Services

1. Routine Patient Care
    - All health care services, items, and drugs for the treatment of cancer, including cancer therapy, chemotherapy, infusion therapy, and radiation therapy.
    - Coverage for orally administered cancer medication, which is provided through prescription drug benefits, will not be less favorable with respect to member cost sharing than intravenously or injected cancer medications.
2. Routine care is covered during a cancer clinical trial.
    - All health care services, items, and drugs that are typically provided in health care; including health care services, items, drugs provided to a patient during the course of treatment in a cancer clinical trial for a condition or any of its complications; and that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.
    - Coverage of routine care not associated with the clinical trial is subject to all terms, conditions, restrictions, exclusions, and other coverage under this Policy.
3. A cancer clinical trial must satisfy all of the following criteria:
    - A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes.
    - The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes and is medically appropriate.
    - The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
    - The trial does one of the following:
        - Tests how to administer a health care service, item, or drug for the treatment of cancer.
        - Tests response to a health care service, item, or drug for the treatment of cancer.

  - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
  - Studies new uses of health care services, items, or drugs for the treatment of cancer.

- The trial is approved phase I, II, III or IV clinical trial and approved by one of the following:
  - The National Institute of Health or one of its cooperative groups or centers, under the federal department of health and human services.
  - The Federal Food and Drug Administration (FDA).
  - The Federal Department of Defense.
  - The Federal Department of Veterans Affairs.

Covered with Prior Authorization
Clinical trials provided outside of the Gundersen Health Plan Network must meet all of the above requirements for coverage and require prior authorization.

Non-Covered Services
1. Routine patient care does not include the health care service, item, or investigational drug that is the subject of the cancer clinical trial. It does not include any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. Also it does not include an investigational drug or device that has not been approved for market by the FDA;
2. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility providing the cancer clinical trial;
3. Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient;
4. Any services, items, or drugs, that are eligible for reimbursement by a person other than us, including the sponsor of the cancer clinical trial; and
5. Experimental clinical trials for cancer treatment.

CARDIAC REHABILITATION

Covered Services
1. Phase I cardiac rehabilitation; and
2. Phase II cardiac rehabilitation when:
   - Provided in an outpatient department of a hospital, in a medical center, or in a clinic program.
   - Cardiac Rehabilitation therapy is covered for patients who have had:
     - A heart attack in the last 12 months;
     - Coronary bypass surgery;
     - Heart valve repair/replacement;

- Percutaneous transluminal coronary angioplasty (PTCA) coronary stenting;
- Stable angina pectoris;
- A heart or heart-lung transplant; or
- Other open heart surgery procedures.

Non-Covered Services

1. Phase III cardiac rehabilitation.

CHIROPRACTIC SERVICES

Covered Services

1. Chiropractic services, including manipulative treatment and therapeutic procedures and modalities for the treatment of an illness or injury.

Non-Covered Services

1. Maintenance or palliative therapy; and
2. Items including, but not limited to, pillows, nutritional supplements, exercise programs or equipment.

Maintenance Therapy is defined as *ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. We make the determination of what constitutes maintenance therapy after reviewing an individual's case history or treatment plan submitted by a provider of health care.*

CLINICAL TRIALS

Covered Services

1. Routine costs, items and services associated with the clinical trial are covered to the same extent they would otherwise be eligible for coverage.
    - The clinical trial must be a Phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.
    - The member participating in the clinical trial must be eligible to participate in the trial according to the trial protocol and the referring health care professional's medical information establishing appropriateness.

Covered with Prior Authorization

Clinical trials provided outside of the Gundersen Health Plan Network, as well as outside the state in which the member resides, must meet all of the above requirements for coverage and require prior authorization.

Non-Covered Services

1. Routine patient care does not include the health care service, item, or investigational drug that is the subject of the cancer clinical trial. It does not include any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. Also it does not include an investigational drug or device that has not been approved for market by the FDA;
2. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;
3. Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient;
4. Any services, items, or drugs, that is eligible for reimbursement by a person other than us, including the sponsor of the cancer clinical trial; and
5. Clinical trials that are experimental or not approved Phase I, II, II or IV clinical trials.

DENTAL (*Iowa Code 514C.20*) AND ORAL SURGERY

Covered Services

1. Covered services include services required because of injury, accident, or cancer that damages sound natural teeth as long as the patient was covered under the policy during the time of the injury or sickness causing the damage. Care must be completed within 12 months of the occurrence. Associated radiology services are included.
2. Anesthesia and hospitalization charges for dental care are covered for covered persons who is a child under five years of age upon determination by a licensed dentist and the child's treating physician that such child requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective. Such coverage applies regardless of whether the services are provided in a hospital or dental office. *(Iowa Code 514C.20)*
3. Anesthesia and hospitalization charges for dental care are covered for covered persons who upon a determination by a licensed dentist and the member's treating physician, has one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center. *(Iowa Code 514C.20)*
4. Anesthesia to include local anesthesia, general anesthesia and intravenous sedation when medically necessary and performed in association with an eligible procedure;
5. Excision of tumors and cysts of the oral structures for pathological examination;
6. Oral examinations, consultations and office visits when performed in association with a covered procedure or diagnosis;
7. Surgical procedures to correct bodily injury to the oral structures;

8. X-rays when performed in association with a covered procedure or diagnosis;
9. Surgical removal of partially or completely unerupted impacted teeth (e.g., wisdom teeth)

Covered with Prior Authorization

1. Osteotomies when performed to correct a functional defect; and
2. Temporomandibular Joint Dysfunction (TMJ). TMJ is defined as *a disorder of the jaw joint(s) and/or associated parts, resulting in pain or inability of the jaw to function properly.* Coverage is provided for surgical and nonsurgical correction of TMJ, including reduction of dislocations and displacements. Surgical procedures are covered when: the condition is caused by a congenital, developmental or acquired deformity, disease or injury; the procedure is reasonable and appropriate for the diagnosis or treatment of the condition; the procedure is being performed to control or eliminate pain, infection, disease or dysfunction. Nonsurgical treatment including intraoral splint therapy is covered when considered medically necessary and approved by us.

Non-Covered Services

1. Dental treatment, services and supplies not specifically indicated as covered services, including but not limited to:
   - Routine and prophylactic dental care.
   - Crowning or capping of teeth;
   - Extraction of teeth;
   - Fillings or dental restoration;
   - Orthodontics and any other services related to correction of malocclusion or TMJ;
   - Replacement of lost teeth and all oral surgical services related to the replacement of lost teeth including dentures and partial dentures, bridges and implants;
   - Root canal procedures;
   - Apicoectomy (Excision of apex of tooth root) and retrograde fillings;
   - Excision of exostoses of the jaws and hard palate;
   - Frenectomy (Incision of the membrane connecting the tongue, cheek or lip to associated dental mucosa);
   - Gingivectomy;
   - Periodontal surgical and non-surgical procedures including grafting and osseous surgery if performed to correct a disease process to the extent which warrants surgical intervention;
   - Orthognathic surgery;
   - Crowns, bridges or dentures, and general dental procedures; and
   - The nonsurgical extraction of teeth due to dental disease, even when recommended prophylactically as part of a medical plan of treatment. This exclusion applies, but is not limited to, extraction of teeth prior to a surgical procedure or treatment necessary for a medical condition.

DIABETES SERVICES *(Iowa Code 514C.18)*

Covered Services

1. Diabetic self-management education programs:
2. Preferred diabetic equipment and supplies, including:
    a. Insulin blood glucose meters;
    b. Insulin syringes;
    c. Insulin injection aids;
    d. Installation and use of insulin infusion pump;
    e. Prescribed oral agents controlling blood sugars;
    f. Glucose agents;
    g. Glucagon kits;
    h. Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes;
    i. Blood test strips and tablets (glucose and ketone);
    j. Urine test strips and tablets (glucose and ketone) and
    k. Lancet and lancet devices when provided by a participating pharmacy.

Diabetic Supplies are limited to those listed in our current Drug Formulary/Diabetic Supply Listing. You can review the current listing, by visiting our website at www.gundersenhealthplan.org.

DIABETIC SUPPLIES

	Preferred Brand	Non-Preferred Brand
Strips	$15 Copay	$35 Copay
Lancets	$5 Copay	$25 Copay
Syringes	$5 Copay	$25 Copay
Devices	$15 Copay	$35 Copay

3. Diabetes self-management training and education only under all of the following conditions:
    a. The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.
    b. The diabetic self-management training and education program is certified by the Iowa Department of Public Health. The department shall consult with the American Diabetes Association, Iowa affiliate, in developing the standards for certification of diabetes education programs as follows:

c. Initial training shall cover up to ten (10) hours of initial outpatient diabetes self-management training within a continuous twelve (12) month period for each individual that meets any of the following conditions:
d. A new onset of diabetes.
e. Poor glycemic control as evidenced by glycosylated hemoglobin of nine and five-tenths or more in the ninety (90) days before attending the training.
f. A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

Covered with Prior Authorization

1. Repair or replacement of insulin pump due to normal wear and tear when out of warranty.
2. Continuous Glucose Monitor.
3. Non-preferred diabetic supplies may require a prior authorization for coverage.

Non-Covered Services

1. Repair or replacement of insulin infusion pump due to theft, loss, or damage; and
2. Repair or replacement of blood glucose meters due to theft, loss, or damage.
3. Repair or replacement of continuous glucose monitor due to theft, loss or damage.

DIETARY COUNSELING AND SUPPLEMENTS

Covered Services

1. Dietary counseling when provided in conjunction with treatment of an illness, such as diabetes, hypertension, or morbid obesity and when ordered by a provider consistent with the medical protocol for treatment of that diagnosis; and
2. Dietary counseling visits for treatment of hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
3. Phenylketonuria Testing, Diagnosis, and Treatment including dietary management, formulas (amino acid-based elemental formula for infants), case management, intake and screening, assessment, comprehensive care planning and service referral.

Covered with Prior Authorization

Enteral feedings, equipment, and supplies are covered when the following are met:

1. Feedings must be ordered by an attending physician and/or registered dietician;
2. Meets all medical necessity criteria; and
3. Prior authorization must be updated at least annually.

Non-Covered Services

1. Any weight loss treatment, including but not limited to medications, self-help groups, exercise and weight loss programs, and dietary supplements.

DISPOSABLE MEDICAL SUPPLIES

Covered Services

1. Disposable medical supplies are defined as *items that cannot withstand repeated use or are intended for one-time use, then discarded*. These items are covered when prescribed by a provider during their supervision of a medical illness or injury, and include, but are not limited to syringes, surgical dressings, and ostomy supplies.

Non-Covered Services

1. Medical supplies that do not require the order of a provider and are usually stocked in the home for general use. Examples include, but are not limited to bandages, gauze pads, tape, incontinence supplies, disposable under pads, elastic bandages; and
2. Medical supplies used in conjunction with a non-covered service.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment is defined as *equipment that must:*

1. *Be able to withstand repeated use;*
2. *Be primarily and customarily used to serve a medical purpose;*
3. *Not be generally useful to a person except for the treatment of an injury or illness; and*
4. *Be medically necessary.*

Examples include, but are not limited to mattresses, TENS/Neurostimulators, power operated vehicles, crutches, wheelchairs, hospital beds, equipment used in the administration of oxygen, orthosis and internal and external prosthetic devices, including, but not limited to the initial acquisition of artificial limbs. *(Iowa Reg. 191-71.14(1-9).* Rental or purchase of items is at our option based on cost effectiveness and the type of equipment.

Covered Services

1. Purchase or repair of medically necessary durable medical equipment less than $1,000**;**
2. Compression stockings when prescribed by a provider, up to a maximum of two pairs (4 stockings) per benefit year;

3. Standard breast prosthesis is limited to one per side every 24 months *(Iowa Reg. 191-35.35(1)* Two mastectomy bras are allowed per benefit year; and
4. Replacement batteries for prosthetics and electric wheelchairs.

Covered with Prior Authorization
1. Purchase or repair of medically necessary durable medical equipment over $1,000;
2. Equipment rental;
3. Prothrombin (INR) Time Home Testing System; and
4. Home infusion therapy and associated services and supplies.
5. Authorization is given, if medically necessary, for one form of transportation for members requiring scooters, wheelchairs, or strollers.

Non-Covered Services
1. Equipment, models, or prosthetic devices, whether or not prescribed by a provider, that have features over and above the standard model unless medically necessary as determined by us;
2. Medical supplies and durable medical equipment that are primarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a provider). This includes, but is not limited to air conditioners; air purifiers; vacuum cleaners; motorized transportation equipment; escalators; elevators; ramps; waterbeds; clothing; hypoallergenic mattresses; items for comfort or convenience; cervical or lumbar pillows or cushions; swimming pools; whirlpools; self-help devices not medical in nature; spas; exercise equipment; gravity lumbar reduction chairs; home blood pressure kits; personal computers; motor vehicles or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts;
3. Back-up equipment (a second set);
4. Repairs and replacement of stolen, lost, damaged or destroyed durable medical equipment/supplies; and
5. Home testing and monitoring supplies and related equipment, except those used in connection with the treatment of diabetes and long-term anticoagulant therapy.

EMERGENCY SERVICES *(IOWA CODE 514C.16)*

An emergency is defined as *a medical condition involving acute symptoms of sufficient severity that a person would reasonably expect and medicine to reasonably conclude that a lack of immediate medical attention would result in serious jeopardy to the person's health, impairment to bodily functions or serious dysfunction to one or more organs.* The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition.

Emergency services are covered under your level 1, in-network benefit. Member cost sharing will apply to the in-network level of benefits, including applicable cost sharing, and out of pocket maximums. We do not apply usual and customary payment methodology to emergency services.

Covered Services

1. Emergency services, regardless of whether services are received from a participating provider, when meeting the following definition of medical emergency:
   a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
      i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
      ii. Serious impairment to bodily functions; or
      iii. Serious dysfunction of any bodily organ.
   b. With respect to a pregnant woman who is having contractions:
      i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
      ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

2. Follow up care out-of-network once your condition has stabilized is paid at Level 2, out-of-network, benefits.
3. Voluntary HIV testing when performed while receiving emergency medical services.

Non-Covered Services

1. Take-home medications

GENETIC TESTING

Covered with Prior Authorization

1. Genetic testing for predisposition or carrier status for a genetic disorder when a certified genetic counselor has determined it is likely that you carry a gene mutation that substantially increases your risk of developing the disorder and the presence of a mutation will lead to modifications in future medical care.

2. Testing, when you are already diagnosed with the disorder if therapy or surveillance will be modified based on the presence of a mutation.

Non-Covered Services

1. Testing that is done for the purpose of identifying a mutation that is for the benefit of a non-covered family member; and
2. Testing for reproductive planning.

HEARING SERVICES

Covered Services

1. Initial hearing screening test(s), payable under the Wellness Benefit, limited to one (1) per benefit year; and
2. Hearing examinations provided as part of the treatment for medical conditions;

Covered with Prior Authorization

1. Cochlear implants.

Non-Covered Services

1. Hearing aids, including bone anchored, hearing aid accessories, and repair of hearing aids.

HOME CARE

Home Care is defined as *medically necessary part-time or intermittent services to a homebound patient including skilled home nursing care and home health aide services, physical, speech and occupational therapy, medical supplies, drugs, and medication, laboratory services, and nutrition counseling.*

Skilled Care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist. Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "non-skilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "non-skilled" persons include: range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24 hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.*

Covered with Prior Authorization

1. Part-time or intermittent home skilled nursing care that is part of the home care plan, by or under the supervision of a registered nurse or medical social worker;
2. Private duty nursing (at least 90 – 110 visits);
3. Physical, respiratory, occupational, speech therapy, or nutritional counseling;
4. Home infusion therapy; and
5. Medical supplies, drugs, and laboratory services, covered to the same extent they would have been covered if you were confined in a hospital.

Non-Covered Services

1. Homemaker or caretaker services, including sitter or companion services, housecleaning, or household maintenance;
2. Skilled nursing care when the only purpose is to obtain a blood sample.

HOSPICE SERVICES

Hospice Services are designed to meet the needs of a terminally ill patient. Approved services can be provided in a facility or in the home. We require notification only for the initial admission to hospice and any inpatient hospice admission.

Covered Services

1. Hospice care when provided by a hospice facility that is approved by us. There are four levels of care provided by a licensed hospice program: routine home care, continuous home care, inpatient respite care, and general inpatient care;
2. A hospice care program consists of, but is not limited to the following: hospice physician services, professional services of a registered nurse or licensed practical nurse, physical therapy, occupational and speech therapy, medical and surgical supplies, durable medical equipment, prescribed drugs, in-home laboratory services, medical social service consultations, and dietitian services;
3. Pastoral services and family counseling related to your condition including bereavement counseling for one year after your death; and
4. Medically necessary ambulance transportation including non-emergent ambulance transportation.

Non-Covered Services

1. Private duty nursing when confined in a hospice facility;
2. Funeral arrangements;
3. Financial or legal counseling, including estate planning or drafting of a will;
4. Homemaker or caretaker services, including sitter or companion services; housecleaning; or household maintenance;
5. Services of a social worker other than a licensed clinical social worker;

6. Services by volunteers or persons who do not regularly charge for their services, including family members;
7. Services by a licensed pastoral counselor to a member of his or her congregation; and
8. Room and board in a skilled nursing facility.

HOSPITAL SERVICES

Covered Services

Inpatient and outpatient hospital services are covered when provided by a hospital or free-standing surgical facility. Inpatient hospital services include:

1. Daily room and board in a semi-private room, ward, intensive care or coronary care unit, including general nursing care. Benefits for a private or single room are limited to the charges for a semi-private room in the hospital where you are confined unless medically necessary;
2. Hospital services and supplies furnished for your treatment during confinement, including drugs administered to you as an inpatient;
3. Inpatient confinement in a non-participating hospital in the case of an emergency medical condition or with an approved referral; and
4. Inpatient hospitalization for rehabilitation is included in the skilled nursing/swing bed benefit and is limited to 90 days per benefit period.

Outpatient hospital benefits include services, drugs and supplies when provided for the following:

1. Emergency treatment provided at the nearest facility equipped to care for your condition;
2. Surgical day care;
3. Treatment such as intravenous and oral medication, anesthesia, blood and blood products and their administration, chemotherapy, inhalation therapy, radiation therapy, physical therapy and kidney dialysis;
4. Diagnostic testing which includes laboratory, x-ray, and other diagnostic testing; and
5. Observation level of care.

Non-Covered Services

1. Continued hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting i.e., skilled nursing facility;
2. Hospital or observation stays which are extended for reasons other than medical necessity, such as lack of transportation, lack of caregiver, and inclement weather;
3. Take-home medications;
4. Convenience items such as guest trays;
5. Educational materials; and
6. A private room that is not medically necessary, or is at your request.

IMMUNIZATIONS

Covered Services

1. Immunizations as recommended by the Centers for Disease (CDC) Control Advisory Committee in Immunization Practice or the American Academy of Pediatric Committee on Infectious Disease.

Non-Covered Services

1. Immunizations solely for the purpose of travel, employment, or education regardless of whether they are recommended by the CDC.

KIDNEY DISEASE TREATMENT

This benefit includes, but is not limited to dialysis, transplantations, donor-related services, diagnostic and therapeutic testing, related outpatient medications, and related physician charges.

Covered Services

1. Treatment of kidney disease including kidney dialysis.

MATERNITY/NEWBORN *(IOWA CODE 514C.12 and IOWA CODE 514C.1)*

Covered Services

1. Treatment of pregnancy includes the following:
   - Prenatal Care is defined as *the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists*.
   - Coverage for inpatient hospital care and post-natal care;
   - Complications of pregnancy are payable as any other covered illness at the point the complication sets in;
   - 48 hours of inpatient hospital care following vaginal delivery and 96 hours of inpatient hospital care following a caesarean section delivery. The length of stay coverage begins is when a delivery occurs in a hospital (at the time of delivery). For deliveries outside the hospital, the stay begins at the time the mother and/or newborn are admitted. The decision of whether an admission is in connection with childbirth is a medical decision to be made by your attending provider, not us. Coverage will be provided for a shorter length of stay if the attending provider, in consultation with the mother, decides on an earlier discharge. Coverage will be provided for a longer length of stay if medically necessary. We are prohibited from requiring

precertification for the minimum stay; however, we may impose continued stay approval for the portion of stay after the 48 or 96 hours; and

- If we terminate our contract with a participating provider, or if a participating provider moves out-of-network, we shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the childbirth and delivery (*Iowa Code 514C.12*).

2. Nursery room, board, and care;
3. Routine examination and other routine professional services rendered to the newborn child before release from the hospital;
4. Circumcisions;
5. Necessary care and treatment of all medically diagnosed congenital defects, birth abnormalities, prematurity, and the functional repair or restoration of any body part when necessary to achieve normal body functioning;
6. Well-baby care rendered after release from the hospital;
    - In the event of a discharge from the hospital prior to 48 hours following a vaginal delivery, or 96 hours following a delivery by cesarean section, a post discharge follow-up visit to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician; and
7. Breast feeding support, supplies, and counseling.
    - Purchase of basic electric breast pump or basic manual breast pump, in conjunction with each birth.

Non-Covered Services

1. Continued stay after discharge for mother when infant remains hospitalized
2. Continued stay after discharge for newborn when mother remains hospitalized
3. Hospital-grade electric breast pumps
4. Home delivery.

<u>MENTAL HEALTH, ALCOHOL & OTHER DRUG ADDICTIONS (MH/AODA)</u>
(Iowa Code 514C.22 and 514C.27)

Covered Services

1. Medically necessary inpatient treatment of nervous and mental disorders, or alcohol and other drug abuse problems, while confined in one of the following qualified treatment facilities. A qualified treatment facility is defined as *a facility, institution, or clinic duly licensed and operating within the scope of its license*. This type of care would include programs approved under the following:
    - Medically managed detoxification
    - Medically monitored residential detoxification

- A psychiatric unit including detoxification and psychiatric bed of an acute care general hospital

2. Medically necessary outpatient treatment of nervous and mental disorders, or alcohol and other drug abuse problems, while not confined to a hospital or qualified treatment facility. A qualified treatment facility is defined as *a facility, institution, or clinic duly licensed and operating within the scope of its license*. This type of care would include ambulatory detoxification service.
3. Medications provided as part of an outpatient treatment program.
4. Office visits for the purpose of medication therapy management.

Covered with Prior Authorization

1. Transitional treatment, offered by a provider, certified by the Department of Human Services and received in an outpatient setting that is more intensive than traditional outpatient care, but less restrictive than traditional inpatient care. Approved treatment programs are required to provide a minimum of 4 hours of structured treatment daily. Treatment may include partial hospitalization programs provided in a qualified facility.
2. Coverage for Emergency Court Orders, Detention or Commitments is limited to commitments or court orders. If a member is examined, evaluated or treated for a nervous or mental disorder pursuant to a detention, commitment or a court order, and a participating provider is available, the covered expense will be payable in accordance with the terms and provisions of this Policy.

Non-Covered Services

1. Hypnotherapy, marriage counseling, residential care, or biofeedback relating to mental health services,
2. Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, custody, or visitation evaluation, unless such treatment or therapy is normally covered by us,
3. Sexual counseling services, including but not limited to, the treatment of sexual dysfunction, sexual inadequacy and inhibited desire,
4. Services by a non-payable provider as determined by us, including providers practicing in non-certified facilities within the state of Iowa.

PHYSICIAN/CLINICIAN SERVICES/QUALIFIED PRACTITIONER SERVICES

A qualified practitioner is defined as *state licensed, practicing within the scope of their license, and practicing in a state licensed facility/office in accordance with the Health Plan standards and based on Iowa law. A physician is a person who is duly licensed by an appropriate government authority as Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.), acting within the scope of their license.* A clinician is defined as *a physician assistant, clinical nurse practitioner, nurse midwife, medical technician, physical*

therapist, and other similar health care providers that provide services under the supervision of a qualified provider.

Covered Services:

1. Office visits, including specialists.
2. Inpatient visits.
3. Surgery services.
4. Anesthesia services.
5. Services provided by licensed physician assistants and licensed advanced registered nurse practitioners (*Iowa Code 514C.11*).
6. Second opinions.

Per *Iowa Code 514C*, if we terminate our contract with a participating health care provider while you are undergoing a specified course of treatment for a terminal illness or a related condition, you may continue to receive treatment from that provider for the terminal illness or related condition, for a period of up to ninety (90) days. After ninety (90) days, covered services will be payable at your Level 2 benefits.

PODIATRIC SERVICES

Covered Services

1. Podiatric services, including non-operative treatment for a condition of the foot, including but not limited to, the following: mycotic nails; a metabolic, neurologic or peripheral vascular disease; or when performed as a necessary and integral part of an otherwise covered expense, such as diagnosis and treatment of ulcers, wound, or infections.

Non-Covered Services

1. Routine hygiene and maintenance care such as trimming corns, calluses, and nails;
2. Cutting, trimming, or other nonoperative partial removal of toenails;
3. Treatment of flexible flat feet; and
4. Medications used to treat onychomycosis.

PRESCRIPTION DRUGS

Prescription drugs are defined as *the written order from a qualified provider for any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription."*

Covered Services

If coverage of prescription drugs is noted on the Summary of Benefits and Coverage, coverage includes drugs and biologicals: 1) which by law require a

written prescription; 2) which are prescribed by a qualified provider for treatment of a diagnosed illness or injury; and 3) are purchased from a participating pharmacy after the applicable copayment and/or coinsurance amount. Covered prescription drugs are limited to those listed in our current formulary unless a prior authorization is obtained through the formulary exception process.

A formulary is defined as *a list of medications identified by our interdisciplinary Pharmacy and Therapeutics Subcommittee composed of physicians, pharmacists, nurses, and other healthcare professionals who work in collaboration using their individual expertise. Medications are reviewed for efficacy, adverse effects, and cost in an effort to maintain a high-quality cost efficient foundation for drug therapy.* Please call Customer Service at the telephone number located on page 5 of this Policy to obtain a current listing of the formulary since it is frequently updated. You also can view the most current formulary by visiting our web site at www.gundersenhealthplan.org/formulary.

If your drug is not included in the formulary, you or your physician may request coverage through an exception process. First, please contact Customer Service to confirm that your drug is not covered. If you find it necessary to use a non-formulary medication, you may request an exception for coverage under essential health benefits. The following are examples of when a formulary exception may be needed:

- A formulary drug causes an adverse reaction;
- A formulary drug is contraindicated; for example it negatively interacts with another medication; or
- Prescriber demonstrates that a non-formulary drug must be used to provide maximum medical benefits.

To make an exception request, we will need supporting documentation from your provider. You may use our standard prior authorization form which is available via our website at www.gundersenhealthplan.org/drugPA form. If the request is approved, coverage will be granted following the same applicable benefits as a formulary drug. This includes any cost-sharing counting toward your annual maximum out-of-pocket limitation.

When obtaining prescriptions, you must present your health plan identification (ID) card. It is your responsibility to use participating, in-network pharmacies; if you do not you may pay more for your medication.

In-network, participating pharmacies will bill the Pharmacy Benefit Manager (PBM) directly and the pharmacy will collect your share of the cost. If you do not use your ID card and are required to pay the full cost of the medication; you may submit your itemized pharmacy receipt to us. Your claim will be processed through our PBM and you will be reimbursed at the current contracted rate minus the applicable copayment. Any difference between the contracted rate and the amount

you paid will be your responsibility. If you are required to pay the full cost of a prescription as the result of emergent care, you will be reimbursed in full minus the applicable copayment or cost sharing.

Prescription medications obtained from out-of-network non-participating pharmacies are covered only if related to urgent or emergent care. If you are required to pay the full cost of a medication under these circumstances, you can submit your itemized pharmacy receipt to us and your claim will be processed through our claims administration department. You will be reimbursed based upon plan benefits for out-of-network cost sharing.

All claims submitted for reimbursement are reviewed to determine if the medication you purchased requires step therapy, prior authorization, or has quantity limits in place. Unless deemed emergent, we may ask the prescriber for additional information before processing the claim to determine payment.

Certain prescription drugs require prior authorization or may be subject to Step Therapy. We have implemented Step Therapy programs in several drug classes where generics or lower cost brand name drugs are available and are equally effective. If there is medical documentation to indicate that the first line drug was unsuccessful, or that you are unable to attempt trial of first line drugs, your physician may submit a drug prior authorization for review. If approved, the authorization will allow you to move directly to the second line of drugs in that drug class. Upon enrollment and upon your request you will receive the Prior Authorization Medication List (see Obtaining Prior Authorization within Section 2).

Generic equivalents may be dispensed by your pharmacy if allowed by your provider or by law. If you choose to purchase the brand name drug when a generic equivalent is available; you will be required to pay what is referred to as ancillary charges. Ancillary charges are defined as *the difference in cost between the brand medication and the generic medication.* Any ancillary charges will be your responsibility in addition to your copayment or coinsurance.

One copayment and/or applicable coinsurance will apply to each prescription fill in a quantity not to exceed a 30-day supply or quantity limits established by us. Drugs on the maintenance list may be dispensed in a quantity sufficient for a 90-day supply for three copayments or applicable coinsurance. Drugs obtained through the mail service pharmacy, if noted on your Summary of Benefits and Coverage may be dispensed in a quantity sufficient for a 90-day supply for three copayments and/or applicable coinsurance as indicated by your Summary of Benefits and Coverage. Any drug listed within the Specialty tier will only be allowed in 30 day supplies.

Experimental or investigational drugs prescribed by a provider for the treatment of HIV infection or a medical condition arising from or related to HIV infection are covered if the drug is in, or has completed a Phase III clinical investigation. Such

investigation must have been performed according to federal regulations. The drug must be prescribed and administered in accordance with the treatment protocol approved for it under federal regulations.

Prescription drugs recently approved by the FDA may be excluded from coverage until reviewed and approved by us.

Prescription contraceptive drugs or prescription contraceptive devices which prevent conception and which are approved by the United States Food and Drug Administration, or generic equivalents approved as substitutable by the United States Food and Drug Administration are covered. (*Iowa Code 514C.19*)

Immune Globulin and Anti-hemophilic Factor drugs must be provided by a participating Exclusive Specialty pharmacy.

All FDA- approved prescription contraceptive drugs will be covered with no cost sharing (copayment/coinsurance) as follows:

- All generic contraceptive drugs;
- All brand name contraceptive drugs with no generic equivalent; or
- Brand name contraceptive drugs, which have generic alternatives, ***only*** if the prescribing practitioner states that “Brand is Medically Necessary.”

Non-Covered Services

1. Medications purchased from a non-participating pharmacy unless urgent or emergent;
2. Over-the-counter medications and their equivalents (unless the medication has been approved for coverage by the Pharmacy and Therapeutics Committee);
3. Replacement drugs (lost, stolen, damaged or destroyed unless an override is allowable per the plans’ internal policy-case by case review is required);
4. Drugs used for the treatment of obesity;
5. Drugs used to enhance athletic performance;
6. Drugs requiring prior authorization that was not obtained;
7. Drugs used for cosmetic purposes;
8. Emergency over-the-counter (OTC) contraceptives unless prescribed by a physician (e.g. Preven and Plan B);
9. Medication quantities exceeding the limitations established by the Plan;
10. Specialty drugs in quantities greater than a 30 day supply;
11. Investigational and or experimental drugs with the exception of investigational drugs used for the treatment of HIV;
12. Charges for medications administered during a nursing home stay;
13. Take home prescription drugs dispensed by a hospital or other outpatient facility;
14. Medications with no approved FDA indication;
15. Certain medications used to prevent a travel related illness;
16. Drugs that do not meet prior authorization criteria for medical necessity; and

17. Both oral and injectable drugs used to treat impotence or erectile dysfunction.
18. Immune Globulin and Anti-hemophilic Factor Drugs received by a non-participating Exclusive Specialty pharmacy.

Covered With Prior Authorization

1. Step therapy medications
2. IV Drugs, biologicals, and certain oral medications

PULMONARY REHABILITATION

Covered Services

1. Medically necessary, medically supervised outpatient pulmonary rehabilitation.

RECONSTRUCTIVE SURGERY OR PROCEDURES

Covered Services

1. Medically necessary correction of a functional defect caused by an injury or illness;
2. Reconstructive surgery performed as a result of an injury or illness if surgery is part of a continuous treatment plan from the time of injury or illness;
3. Reconstructive surgery for a congenital disease or anomaly of a child which results in a functional defect; and
4. Breast reconstruction (*Iowa Reg. 191-35.35(1))*:
   - Reconstruction of the breast on which the mastectomy has been performed;
   - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   - Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

Non-Covered Services

1. Plastic or cosmetic surgery or procedures, and any related services or supplies that are undertaken solely to improve your appearance. Psychological reasons do not make surgery medically necessary.

   Plastic or Cosmetic Surgery is defined as *any operative procedure performed primarily to improve physical appearance; to treat a mental or nervous disorder through a change in bodily form; to change or restore bodily form without correcting or materially improving a bodily function.*

REPRODUCTIVE HEALTH

Covered Services

1. Services necessary for the initial diagnosis of infertility, including sonoHSG and HSG, progesterone level outside pregnancy, FSH/estradiol , and semen

analysis (each covered once per lifetime for the initial diagnostic evaluation of infertility);
2. Birth control devices/contraceptives unless otherwise specifically excluded *(Iowa Code 514C.19);* and
3. Elective sterilizations, including vasectomies and tubal ligation.
4. Treatment, services or supplies resulting from your services as a surrogate mother (this does not apply to a non-member that you contract as a surrogate mother); and
5. Pregnancy resulting from your services as a surrogate mother (this does not apply to a non-member that you contract as a surrogate mother).

Covered with Prior Authorization *(Iowa Reg. 191-71.14)*
1. Elective abortions when the life of the mother would be endangered if the fetus were carried to full term, or if the pregnancy is the result of rape or incest

Non-Covered Services
1. Donor sperm or embryo;
2. The reversal of elective sterilization procedures;
3. Treatment, services or supplies for a surrogate mother who is not covered under this policy;
4. Amniocentesis or chorionic villi sampling (CVS) solely for gender determination;
5. Infertility services including testing, treatment, evaluation and medication (oral and injectable), following the diagnosis of infertility (other than the diagnostic tests listed in Covered Services);
6. Contraceptives which do not require the order of a physician;
7. Emergency over-the-counter (OTC) contraceptives (e.g. Preven and Plan B); and
8. Counseling, treatment including but not limited to vacuum erection devices or implants, or medication for sexual or erectile dysfunction, whether or not prescribed or provided by a participating provider.

SHOE INSERTS/ORTHOTICS

Covered Services
Orthopedic shoes, foot orthotics, and other supportive devices will be covered only under the following conditions:
1. Shoes only when the shoe is an integral part of a leg brace and its expense is included as part of the cost of the brace;
2. Custom molded foot orthotics for treatment of diabetic related foot conditions;
3. Custom molded foot orthotics for treatment of foot conditions related to Peripheral Vascular Disease;
4. Therapeutic shoes for persons with diabetes; and
5. For children up to the age of three years old with the diagnosis of metatarsus adductus, atavistic great toe, and/or club feet. Covered for infants up to 1 year old with diagnosis of severe calcaneal valgus.

SKILLED NURSING FACILITY CARE

A Skilled Nursing Facility is defined as *an institution which is a state-licensed facility that maintains and provides the following:*

1. *Permanent and full-time bed care facilities for resident patients;*
2. *A physician's services available at all times;*
3. *A registered nurse or physician in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty;*
4. *A daily record for each patient; and*
5. *Continuous skilled care for ill or injured persons during convalescence from illness or injury.*

A skilled nursing facility is not, except by coincidence, a rest home, a home for care of the aged, or a facility engaged in the care and treatment of alcoholics, drug addicts, or persons with mental disorders.

Confinement must be within 24 hours after discharge from a covered hospital confinement. You must be confined for continued treatment of the same condition for which you required hospitalization. Your doctor must certify that your confinement is medically necessary for skilled care or treatment of the injury or illness that caused the hospital confinement. Skilled nursing facility services are limited to 90 days per benefit year.

Skilled Care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist. Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "non-skilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "non-skilled" persons include range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24 hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.*

Covered with Prior Authorization

1. Skilled nursing facility charges and costs associated with an approved skilled stay when provided by a state licensed or Medicare certified skilled nursing facility.

Non-Covered Services

1. Custodial care and services, including room and board while residing in an assisted living facility. *The definition of custodial care is a provision of room and board, nursing care, personal care or other care designed to assist an individual in the activities of daily living. Such care does not entail or require the continuing attention of trained medical personnel, such as nurses. Custodial care includes those services which constitute personal care, such as help in walking, getting in and out of bed, assistance in bathing or eating, using the toilet, preparing special diets, 24-hour supervision for potentially unsafe behavior, or supervision of medication which usually can be self-administered. Care may still be custodial even though such care involves the use of technical medical skills if such skills can be easily taught to a layperson. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the physician, that medical or surgical treatment will enable that person to live outside an institution. Custodial care includes rest cures, respite care, and home care provided by family members;*
2. State bed tax for skilled nursing facility stays; and
3. Room and board charges associated with a hospice related stay.

<u>SWING BED CARE</u>

A Swing Bed is defined as a *distinct unit, or designated bed in a licensed hospital. Swing beds are used primarily for short term, post-acute hospital stays to resolve a short-term medical need or to continue rehabilitation for a limited period of time.*

Skilled Care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist. Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "non-skilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "non-skilled" persons include range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24 hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.*

Confinement must be within 24 hours after discharge from a covered hospital confinement. You must be confined for continued treatment of the same condition for which you required hospitalization. Your doctor must certify that your confinement is medically necessary for skilled care or treatment of the injury or illness that caused the hospital confinement. Swing bed services are limited to 90 days per benefit year. Benefits for swing bed services are included and applied to the skilled nursing facility maximum benefit limits.

Covered with Prior Authorization
Facility charges and costs associated with an approved swing bed stay when meeting the following criteria:

1. Your doctor must certify your stay as medically necessary and daily skilled needs are identified;
2. You must be confined and receive skilled treatment for which you were hospitalized. Confinement must be within 24 hours after discharge from a covered hospital confinement;
3. Intensity and frequency of skilled services requires 24-hour nursing intervention;
4. Frequent or daily physician monitoring is needed;
5. Skilled services will be for a short-term period and may not exceed seven days; and
6. There is likely no further need for skilled nursing services post discharge.

<u>THERAPY (PHYSICAL, SPEECH & OCCUPATIONAL)</u> ***(Iowa Code 514C.22)***

Covered Services

1. Medically necessary health care services of outpatient physical, speech, and occupational therapy when provided for rehabilitative reasons that help a person learn, keep, restore or improve skills and functioning necessary to address a health condition to the maximum extent practical. Therapy must be ordered by a qualified physician and provided by a qualified provider. Therapies are limited to 20 visits per therapy discipline (speech, occupational and physical) per year without prior authorization. Therapies exceeding 20 visits per year, per therapy discipline require prior authorization.
2. Medically necessary health care services of outpatient physical, speech, and occupational therapy when provided for habilitative reasons that help a person learn, keep, restore or improve skills and functioning necessary to address a health condition to the maximum extent practical. Therapy must be ordered by a qualified physician and provided by a qualified provider. Therapies are limited to 20 visits per therapy discipline (speech, occupational and physical) per year without prior authorization. Therapies exceeding 20 visits per year, per therapy discipline require prior authorization.
3. Speech screening examinations are limited to the routine screening tests performed by a provider to determine the need for correction.

Covered with Prior Authorization

1. Rehabilitative therapies in excess of 20 visits per therapy discipline per year require prior authorization.
2. Habilitative therapies in excess of 20 visits per therapy discipline per year require prior authorization.

Non-Covered Services

1. Maintenance therapy or treatment that does not result in documented sustained improvement. Maintenance Therapy is defined as *ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated;*
2. Art, dance, music, or animal-based therapies;
3. Therapy services such as recreational or education therapy, physical fitness or exercise programs, including Phase III of cardiac rehabilitation;
4. Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, custody, or visitation evaluation, unless such treatment or therapy is normally covered by us;
5. Services provided by a therapist living in the patient's home or who is a member of the immediate family; and
6. Educational or vocational therapy, including but not limited to counseling, evaluation, testing, treatment, videos or video games, and books.

TOBACCO/SMOKING CESSATION

Covered Services

1. Medications for tobacco/smoking cessation that require a prescription, limited to 180 days per benefit year.
2. Reimbursement of approved smoking cessation programs; and
3. Nicotine inhalation system or nasal spray that requires a prescription is covered for 90 days, per benefit year. An additional 90 days may be covered, upon submission of your smoking cessation program completion certificate.

TRANSPLANTS

Covered Services

Cornea transplants are covered.

Covered with Prior Authorization

Coverage of solid organ and bone marrow transplants require prior authorization by us. Transplantation and retransplantation may be covered as long as the procedure has been established to be reasonable by nationally recognized academic transplant centers and is approved by us.

Kidney	Kidney/Pancreas	Liver	Intestinal

Heart/Lung	Lung Heart	Bone Marrow Stem Cell

Donor expenses are covered when included as part of your bill. Procurement costs for transplants that are a covered expense will be included in and applied toward the recipient's benefit limitation(s).

Non-Covered Services
1. Purchase price of bone marrow, organ, or tissue that is sold rather than donated;
2. Lodging and transportation expenses; and
3. Transplant services from providers and/or facilities not approved by us.

URGENT CARE

Urgent Care is defined as the *care that you need sooner than a scheduled physician's visit, but is not an emergency. Some examples of urgent care are sprains, minor cuts and burns, drug reactions, and non-severe bleeding.*

Covered Services
1. Urgent care services.

VISION CARE

Covered Services
1. Initial vision exam payable under the Wellness Benefit, limited to one (1) per benefit year;
2. Eye examinations provided as part of the treatment for medical conditions;
3. Initial lenses after cataract surgery, one lens per surgical eye, when provided within 12 months of surgery;
4. The initial fitting and replacement lenses as a result of disease progression when you have a diagnosis of keratoconus, limited to two lenses per affected eye, per benefit year; and
5. Eye glasses for children under the age of 19 include coverage of one standard pediatric or standard adult frame per year and one pair of standard glass, plastic, or polycarbonate lenses per year. Lenses include all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, scratch resistant coating, oversized and glass-grey #3 prescription sunglass lenses. Contact lenses may be substituted for eye glasses and equivalently are limited to one pair of rigid lenses, or up to 24 pairs of soft disposable lenses per year.
6. Corrective eyewear for adults is covered up to $150.00 per benefit year toward the cost of frames, lenses, contact lenses, costs for tints, polishing or other lens treatments. This benefit is available through in-network providers only.

7. Cataract surgery, including the placement of a standard monofocal intraocular lens implanted at the time of cataract surgery or as a separate subsequent surgical procedure.

Non-Covered Services

1. Non-prescription eyewear;
2. Deluxe frames;
3. Professional services including measurement, fitting, and adjustments;
4. Vision therapy, or orthoptics treatment (eye exercises);
5. All refractive surgical procedures to correct visual acuity and refractive disorders of the eye.
6. The additional cost of a specialty intraocular lens (over the cost of a standard monofocal intraocular lens) implanted at the time of cataract surgery or as a separate subsequent surgical procedure. Specialty intraocular lenses include, but are not limited to, toric astigmatism-correcting intraocular lenses and multifocal presbyopia-correcting intraocular lenses. (If a member chooses to have a specialty intraocular lens implanted, the member may pay for the additional cost of this lens.)

WELL-CHILD CARE *(IOWA REGULATION 191.80.5)*

Covered Services

1. Well-child exams from birth through age 6 as recommended in the Preventive Care Guidelines or by the American Academy of Pediatrics, including vision and hearing screening done in conjunction with the exam;
2. Immunizations, as recommended by the Centers of Disease Control Advisory Committee in Immunization Practice or the American Academy of Pediatric Committee on Infectious Disease; and
3. Charges for lab services including, but not limited to, screening for lead exposure as well as blood levels for children through 6 years of age. The Department of Human Services shall conduct tests in accordance with recommendations.

WELLNESS

Wellness is defined as *preventive medical services in the absence of symptoms, illness or injury.* Health Plans are required to cover Grade A or Grade B level wellness services recommended by the U.S. Preventive Services Task Force (USPSTF). You can view the complete list at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Wellness Benefits (Preventive Care)	Medical Benefits (Problem-related care)
Wellness services are those received to help you stay "well" when no signs, symptoms or complaints	Medical services are those you receive related to an illness or health condition. If, at a wellness

are present. Wellness services are covered at 100% when completed at Gundersen Health Plan-affiliated provider offices at the frequencies listed below.	exam, you and your doctor discuss a medical problem, there may be extra charges added to the visit. Therefore, you may be responsible for some amounts based on cost sharing (deductible, coinsurance and copay amounts).

The services listed below are covered at 100 percent (no member cost sharing) when you receive them related to wellness care from a participating provider. Wellness care refers to the services received to help you maintain general health, when no signs, symptoms or complaints are present.

1. **An annual adult wellness exam**
   The exam includes an age and gender appropriate history, full examination, and discussion about reducing risks to prevent future disease or illness.

   Examinations requested by a third party may be substituted for the annual wellness examination. Examples of physicals that may be substituted include school admission, sports competition, and for purposes of employment or licensing.

2. **Well child exams**
   Well child visits have no coverage limit through age two. Beginning at age three, one visit is covered per benefit year.

3. **Blood Lead Screening**
   Annual blood lead tests are covered for children through six years of age.

4. **Immunizations**
   The wellness benefit includes routine immunizations such as:
   - Hepatitis B (Hep B)
   - Diptheria, Tetanus, Pertussis (Dtap and Tdap)
   - Inactivated Polio (IPV)
   - Haemophilus influenza type b (Hib)
   - Pneumococcal (PCV)
   - Rotavirus (Rota)
   - Measles, Mumps and Rubella (MMR)
   - Varicella (VAR)
   - Hepatitis A (HAV)
   - Meningococcal (MCV)
   - Human Papilloma Virus (HPV)
   - Influenza
   - Herpes Zoster (Shingles)

5. **Annual hearing and vision exams**

6. **Screening labs and x-rays**
   The following list includes wellness screening labs and x-rays covered at 100 percent when completed in the absence of symptoms. Please note these labs are also eligible if symptoms are present. However, in that case, they apply to medical benefits and your cost-sharing will apply.

To learn about whether you may be due for a preventive screening, refer to the Preventive Care Guidelines at www.gundersenhealthplan.org/healthresources	
Screening Labs and X-rays	**Frequency Limit**
Mammogram to screen for breast cancer	One per benefit year for women of all ages
Pap smear to screen for cervical cancer	One per benefit year for women of all ages
Sexually Transmitted Disease testing • Chlamydia • Syphilis • Gonorrhea • HIV	One of each per benefit year
Cholesterol screening (total lipid profile)	Every five benefit years for adults
Diabetes Screening (fasting glucose/blood sugar)	Every three benefit years for adults
Gynecological exam for women (breast and cervical exam)	One per benefit year for women of all ages
Osteoporosis Screening (bone mineral density)	Every two benefit years after age 60
Prostate Cancer Screenings • Prostate specific antigen (PSA) • Screening digital rectal exam	Each test is covered once per benefit year for men
Hemoglobin to screen for iron deficiency anemia	One at age 1

Colorectal cancer screening	The following are covered: • Colonoscopy screening exams as recommended by a doctor • Sigmoidoscopy/barium enema every 5 benefit years • Fecal occult blood testing every benefit year
Screening for gestational diabetes for pregnant women	One during weeks 24 - 28 of gestation and • One if identified as high risk for diabetes
Human papillomavirus testing for women	One every three benefit years for ages 30 or older

7. Counseling for sexually transmitted infections

8. Screening and counseling for interpersonal and domestic violence for women

9. Certain oral medications for breast cancer prevention

10. Contraceptive methods and counseling

All FDA- approved contraceptive methods, sterilization procedures, and patient education and counseling for women as prescribed by your provider. The following prescription drugs will be covered with no copayment to members:

- All generic contraceptive drugs
- All brand name contraceptive drugs with no generic equivalent
- Brand name contraceptive drugs, which have generic alternatives, ***only*** if the prescribing practitioner states that “Brand is Medically Necessary.”

11. Preventive counseling for a healthy diet

Up to three (3) dietary counseling visits for the treatment of hyperlipidemia and other known risk factors for cardiovascular and diet related chronic disease. (Additional counseling visits are covered under Dietary Counseling.)

X-RAY & LABORATORY TESTS

Covered Services

1. Inpatient and outpatient diagnostic and therapeutic testing ordered because symptoms are present, or to monitor an existing medical condition or illness.

SECTION 5 – GENERAL EXCLUSIONS

An Exclusion is defined as *any medical service or supply listed in this section, or not listed as a covered expense in Section 4 - Benefits: Covered and Non-covered of this Policy.*

The following are General Exclusions of your plan:

1. Acupuncture services;
2. Any and all types of modifications to the home and the items associated with the modifications (e.g., ramps, grab bars, stair lifts, elevators.
3. Any condition, disability or charges resulting from or sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an assault or a criminal act.
4. Any loss caused while engaged in active military or reservists duties as a result of war or any act of war, declared or not; or any act of international armed conflict or any conflict involving armed forces of any international authority;
5. Any services in excess of the maximum benefit limitations;
6. Any services requested by a third party;
7. Any treatment, service or supply not specifically listed as a covered benefit and all associated and related charges;
8. Any treatment or services rendered by or at the direction of a person residing in your household, or a member of your immediate family. Immediate family is defined as *spouse, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in immediate family;*
9. Any treatment or services ordered or rendered by you, for you;
10. Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license;
11. Charges for drugs filled at non-participating pharmacies which exceed our current contracted rates;
12. Charges for missed or canceled appointments;
13. Charges for non-participating provider services which exceed usual and customary;
14. Charges for the services of a blood donor;
15. Chelation therapy;
16. Coma stimulation programs;
17. Communications, lodging accommodations, transportation, and travel time, unless otherwise indicated as being a covered expense;
18. Custodial care;
19. Customization of vehicles and/or lifts for wheelchairs and/or scooters.
20. Dermabrasion;
21. Expenses for medical reports, including preparation and presentation;

22. Experimental or investigational services including treatment or procedures not generally proven to be effective as determined by our Medical Director following review of research protocol and individual treatment plans. Experimental or Investigational is defined as *treatments, procedures, drugs or medicines which our Medical Director determines are experimental or investigational, and that includes one or both of the following:*
    - *The device, drug or medicine cannot lawfully be marketed without approval of the U.S. FDA and approval for marketing has not been given at the time the device, drug or medicine is furnished;*
    - *Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedures, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or its efficacy as compared with the standard means of treatment or diagnosis.*
23. Hair prosthesis, hair transplants or implants, wigs or any treatment of alopecia;
24. Hair removal;
25. Long term acute care (LTAC) facility;
26. Massage therapy when provided by a masseuse;
27. Rental or purchase of hospital-grade breast pumps;
28. Services provided under another plan for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. Examples include coverage by Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation. If coverage under this legislation is optional for you because you could have elected it, or could have had it elected for you, benefits will not be paid for any injury or sickness that would have been covered under the other plan had it been elected;
29. Services and supplies for which no charge is made or for which you would not have to pay without this coverage;
30. Sex transformation surgery and related services;
31. Treatment, services, and supplies furnished by the U.S. Veterans Administration, except for which we are the primary payer under applicable federal law;
32. Work hardening programs, health spas, health clubs, aerobic and strength conditioning, exercise equipment and all related material and products for these programs.

SECTION 6 – CLAIM INFORMATION

TIME LIMIT ON FILING A CLAIM

A claim for benefits should be submitted to us within 60 days after the services are received, or as soon as it is possible. If we do not receive the claim within 12 months after the date it was otherwise required, we may deny coverage of the claim.

HOW TO FILE A CLAIM

When filing a claim it is important to understand your rights and responsibilities. Some services require prior authorization from us pre-service. Failure to obtain necessary prior authorization may result in a denial of coverage, in which case the responsibility of payment may be yours. Please see Section 2 of this document for further information on the timing and process of how to obtain a pre-service prior authorization.

When obtaining treatment at a provider's office or a hospital, please present your health plan ID card to ensure proper claim filing. We will be billed directly post-service for your claim and will notify you of any applicable costs (deductible, copayments or coinsurance) or non-covered charges. If you receive services from a non-participating provider, and are required to make payment, please obtain a claim form or provide us with the following information when requesting payment from us. If the provider is not able to provide you with a claim form, please refer to our website for complete instructions and our claim form. The following information is required when requesting payment of benefits:

- Subscriber's name and address.
- Patient's name and date of birth.
- Number from your ID card.
- Name and address of the provider of the service(s).
- Name and address of any ordering physician.
- A diagnosis from the physician.
- An itemized bill that includes applicable procedure codes or a description of each charge.
- The date of injury or sickness.
- If you have other coverage, please include the name of the other insurance carrier(s).
- Proof of payment.

Submit this information to the following address:

Gundersen Health Plan, Inc.
1900 South Ave., Mail Stop: NCA2-01

La Crosse, WI 54601

You must agree to provide us with any additional information regarding your claim that we may require to process the claim.

You have the right to appeal any decision we make that denies payment of your claim or your request for coverage of a health care service or treatment, including concurrent care decisions. Please see Section 7 of this document for the timing, notices, and process requirements for these rights.

HOW TO FILE A PHARMACY CLAIM

When obtaining prescriptions, you must present your health plan identification (ID) card. It is your responsibility to use participating, in-network pharmacies; if you do not, you may pay more for your medication. If you receive any prescriptions and are required to make full payment, you may submit an itemized receipt to us. You will receive reimbursement for any covered prescription drug services outlined in Section 4 of this document, minus the applicable copayment. Reimbursement will be at the current contracted rates and any difference between this rate and the amount that you paid, will be your responsibility. Send the itemized receipt to the address below and include the following information: the drug name and NDC number, the providers name and NPI number, the date of service, days' supply, quantity filled, and the pharmacy's NABP number.

Gundersen Health Plan, Inc.
Attn: Pharmacy Dept.
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601

PHYSICIAN AND HOSPITAL RECORDS

Physicians and hospitals must provide us with records to help us determine if services are covered. You agree to cooperate with us to execute releases, which authorize physicians, hospitals, and other providers of service to release all records to us regarding such services. It is also a condition of our payment of benefits. All information must be furnished to the extent that we determine necessary in a particular situation and as allowed by applicable law.

MEDICAL MANAGEMENT/ALTERNATIVE TREATMENT

Our Medical Management Department assures that every member receives quality and appropriate care. Our staff consists of registered nurses licensed in the state of Iowa that are specifically trained in case management to make sure that you receive the care you need in the most appropriate setting. In certain circumstances, after reviewing your treatment plan and in consultation with our Medical Director, we reserve the right to recommend an alternative treatment to better serve your needs. You would be informed of the alternative treatment being recommended.

SECTION 7 – APPEAL & EXTERNAL REVIEW PROCEDURES

APPEALS PROCEDURE

We encourage you to contact Customer Service if you have an inquiry, a concern, or a complaint against us, or one of our participating providers. The Customer Service Representative acts as an intermediary for us to resolve any of your issues.
If they are unable to resolve the issue to your satisfaction, they will advise you of your right to appeal an adverse benefit determination in writing with the Member Advocate. You have the right to review the claim file and present evidence and testimony as part of the internal appeals process. The Member Advocate is a person who is employed by us who specializes in the appeal process. The Member Advocate will receive and record your written appeal. He or she will investigate your appeal and assist you through the appeals procedure. They will also advise you or your authorized representative (herein referred to as AR) of the disposition of the appeal and the action taken.

TIME LIMIT ON FILING AN APPEAL

Each time Gundersen Health Plan denies a claim or benefit request, Gundersen Health Plan shall notify you of your right to file an appeal. An appeal must be submitted to the Health Plan within 180 days following receipt of a notification of an adverse benefit determination. If the 180-day time frame in which to file an appeal has expired, the appeal request will not be granted.

An expedited appeal may be requested to change an initial adverse determination for urgent care. Pre-service denials in which you have not received the service will result in a decision within 72 hours of your request.

If your appeal request is for a post-service benefit you will receive a decision within 30 days of your request.

AUTHORIZED REPRESENTATIVE

The definition of an authorized representative is *an individual authorized by you to act on your behalf in pursuing payment of a claim, obtaining a referral/prior authorization or in dealing with all levels of the appeals process. They may: 1) obtain any information about your claims to the same extent that you are able to; 2) submit any evidence; 3) make any statements about fact or law; and 4) make any request or give any notice about the appeal proceedings.* If you appoint your AR to file an appeal for you, you and your AR may, but are not required, to use our Personal Representative Appointment and Authorization to Release Protected Health Information form. We will accept any authorization form that confirms your request for representation during the appeal procedure.

ADVERSE BENEFIT DETERMINATION

The definition of adverse benefit determination means *a denial, reduction, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of a member's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit, resulting from the application of any utilization review, as well failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.* A rescission of coverage will be treated as an adverse benefit determination.

If we fail to adhere to all of the requirements listed with respect to a claim, you are deemed to have exhausted our internal claims and appeals process and may initiate an external review.

APPEAL

The definition of an appeal is *any dissatisfaction with the provision of services or claims practices by us, or any administration of services by us, which is expressed in writing by you or on your behalf.*

CONTINUED COVERAGE THROUGH COMPLETION OF APPEAL PROCESS

The Health Plan will allow members to have continued coverage under their medical benefit plan pending the outcome of an internal grievance/appeal. Continued coverage only applies to concurrent care decisions if the Health Plan has approved an ongoing course of treatment (e.g., inpatient care, SNF, home health care, physical therapy) and any denial, reduction or termination of such course of treatment by the Health Plan before the end of such period of time or number of treatments. Continued coverage does not apply to requests for extension of the course of treatment beyond the already approved period or number.

The Health Plan must continue to provide coverage and make payment for the currently approved ongoing course of treatment while the internal appeal/grievance is under review. The Health Plan is obligated to provide coverage up to the end of the currently approved treatment or final determination, whichever comes first, subject to regulatory and contractual obligations of the Health Plan.

GRIEVANCE and APPEALS COMMITTEE and GOALS

We have established a Grievance and Appeals Committee to review and act upon all member appeals. It reviews all written appeals made by you. It makes a final determination based on your benefit plan and all documentation that is present upon review. We are committed to giving you an opportunity to exercise your right to a fair and quick resolution to any and all appeals. Our appeal procedure has been developed to meet the following goals:

1. To ensure that you receive a fair, just and prompt resolution to appeals;
2. To allow you to be treated with dignity and with respect through the entire appeal process;

3. To inform you of your full rights as they relate to appeal resolution including your right to appeal at each level;
4. To provide a review that takes into account all comments, documents, records, and other information submitted by you, regardless of whether such information was submitted or considered in the initial benefit determination; and
5. To comply with all state and federal regulatory guidelines and policies with respect to member appeals.

The appeal procedure(s) as described in this section will demonstrate our ability to meet the goals stated above.

STANDARD APPEAL PROCEDURE

1. You or your AR must submit your appeal in writing to the Member Advocate. Please forward your appeal to the following address:

Gundersen Health Plan, Inc.
Attn: Member Advocate
1900 South Ave., Mail Stop: NCA2-01
La Crosse, WI 54601
Fax Number: (608)775-8060

2. Within five (5) business days of receipt of your written appeal, the Member Advocate will:
   - Provide you with a written notice acknowledging receipt of your written appeal. They will advise you or your AR of the date and the place of the Committee meeting.
   - Notify you or your AR of the right to appear in person or via teleconference before the Committee. This is to present written or verbal information and to question those responsible for making the initial determination that resulted in the appeal.
   - Resolve and provide written or electronic notification in a culturally and linguistically appropriate manner of your pre-service appeal within thirty (30) calendar days of receipt.
   - Resolve and provide written or electronic notification in a culturally and linguistically appropriate manner of your post-service appeal within sixty (60) calendar days of receipt.
3. If we are unable to resolve your pre-service appeal within thirty (30) calendar days of receipt, we may extend the time period an additional thirty (30) calendar days if we obtain verbal or written authorization from you or your AR. If authorization is not obtained, we will make a determination based on the information available. The Member Advocate will notify you or your AR in writing prior to the expiration of the thirty (30) calendar days of the following: a) that we have not resolved your appeal;

b) the reason why additional time is needed; and c) when resolution can be expected. The extended time period needed for resolution of your appeal shall not exceed 30 calendar days.

4. The Member Advocate will provide you or your AR with written notification of the Grievance and Appeals Committee's final decision. The written notice will include the rationale for the decision. It will also include your right to further appeal if the decision is unfavorable to you.

EXPEDITED (URGENT CARE) APPEAL PROCEDURE

You have the right to access the expedited appeal review process. An expedited appeal means *an appeal where any of the following applies: 1) the standard appeal resolution could: 2) seriously jeopardize your life or health or your ability to regain maximum function; 3) in the opinion of a physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the appeal; 4) a physician with knowledge of your medical condition will be treated as an expedited appeal; or 5) admissions, continued stay or health care services which you received emergency care and have not been discharged from a facility.*

1. You, your AR, or your physician may verbally request an expedited appeal by contacting the Member Advocate at (800)897-1923, extension 58052 or (608)775-8052. Expedited appeals may be submitted either in writing or verbally to the Member Advocate. The Member Advocate will verbally notify you, your AR, or your physician as to whether or not the expedited appeal request will be granted. An expedited appeal will be resolved as quickly as your health condition requires, but no later than 72 hours of our receipt of the request.
2. The Member Advocate will provide you or your AR with both written and verbal confirmation acknowledging your expedited appeal on the same day of receipt of the expedited appeal. It will be reviewed by our Medical Director or their designee for a resolution within 72 hours of our receipt of your expedited (urgent care) appeal.
3. The Member Advocate will:
    - Notify you or your AR by telephone of our decision within 72 hours of our receipt of the expedited (urgent care) appeal; and
    - Follow-up in writing or electronically in a culturally and linguistically appropriate manner within two (2) business days of our decision.
4. If you fail to provide sufficient information to determine covered/payable benefits for your urgent care claim, the plan will:
    - Notify you within 24 hours of the information necessary to complete the claim.
    - Give you at least 48 hours to provide the specified information.
    - Provide you with notice of our decision within 48 hours of the earlier of:

   i. Receiving the specified information; or
   ii. At the end of the time period provided to return the specified information.

5. If our decision is to uphold the initial adverse benefit determination, in whole or in part, then the Member Advocate will provide you or your AR with a written notification including the date and place of the Grievance and Appeals Committee meeting; and your right to appear in person or via teleconference before the Grievance and Appeals Committee. This is to present written or verbal information and to question those persons responsible for making the initial denial that resulted in the expedited appeal. After the Committee has made a decision, you or your AR will be notified of the decision in writing. If the Committee decision is to uphold the initial adverse benefit determination, in whole or in part, the Member Advocate will provide you or your AR with a final decision letter. The final decision letter will include the specific reason for the denial; make reference to the benefit provision, guideline, protocol or other criteria uses to make the decision; or will include claims related information, i.e., date of service denied, health care provider or network, the claim amount denied as it related to your diagnosis and its meaning; as well as treatment code if applicable.
6. The Member Advocate will provide you or your AR with a written notification of the Committee's final decision. The written notice will include the rationale for the decision and your right to further appeal if the decision is not favorable to you.
7. If we determine that your expedited appeal request is not time sensitive, the request will be processed under the standard appeal procedure. The Member Advocate will verbally notify you or your AR of our decision to deny the request for an expedited review. We will also provide you with written notification of our decision not to expedite the review within 72 hours of the request.

SUBMISSION AND RECEIPT OF INFORMATION

At any time during the standard or expedited appeal process, you or your AR may provide us with any written comments, documents, records or any other information regarding your issue. You or your AR can present such evidence in person, in writing, via teleconference, or by fax. Upon your request, we will provide you or your AR with copies of all documents, records, and other information relevant to your appeal issue(s). This information will be provided to you free of charge.

LEGAL ACTIONS

No action can be brought against us to pay benefits until at least 60 days after written proof of loss is furnished. No action can be brought more than three years after the date that the written proof of loss is made. If you pursue review through the voluntary levels of appeal, then the three-year limitation does not begin until the last voluntary level of appeal has been exhausted.

VOLUNTARY OPTION APPEAL

Upon your request we will provide you or your AR with additional information that is related to the voluntary levels of appeal. This information will enable you to make an informed judgment about whether or not to submit your issue in dispute to a voluntary level of appeal. No fees or costs are imposed on you as part of the voluntary level of appeal.

OTHER VOLUNTARY OPTIONS OF APPEAL

1. Iowa Insurance Division

You may contact the Iowa Insurance Division, a state agency that enforces Iowa's insurance laws, and you may file a complaint. You can contact the Iowa Insurance Division by writing to:

Iowa Insurance Division
Market Regulation Bureau
330 Maple St.
Des Moines, IA 50139-0065

Or call (515) 281-6348 or toll-free at (877) 955-1212, or via email at market.regulation@iid.iowa.gov to request a complaint form.

2. EXTERNAL REVIEW

A. Notification of right to external review.

If we denied your request for the provision of or the payment for a health care service or a course of treatment or you did not receive a decision within 30 days following the date you or your AR filed an appeal involving an adverse determination then you have a right to have our decision reviewed by independent health care professionals who have no association with us. This process is called "external review."

You may obtain an external review if:

- Our decision involved an admission, the availability of care, a continued stay, or other health care service that is a covered benefit;
- We denied, reduced or terminated the payment for the service because we determined it did not meet our requirements for medical necessity, health care setting, appropriateness, level of care or effectiveness of the health care service or treatment you requested;
- Our decision was based on a determination that the service or treatment is investigational or experimental;
- Upon agreement by us to waive your request for exhaustion of the internal appeal process requirement. If waived by us, you or your AR may file a request in writing for a standard external review; or
- Rescission of health care Insurance policy or certificate (rescission means the plan retroactively cancels your policy because it maintains that you did

not answer the health questions on the application of insurance completely and accurately).

B. Exhaustion of Internal Appeal Process

Except for requests for expedited external review, a request for external review shall not be made until the member or their authorized representative have exhausted the Health Plan's internal appeal process and have received a final internal adverse benefit determination.

A member or their authorized representative shall be considered to have exhausted the Health Plan's internal appeal process if:

a. The member or their authorized representative filed an appeal involving an adverse determination.
b. The Health Plan failed to issue a written decision within thirty (30) days following the date the member or their authorized representative filed an appeal involving an adverse determination; unless an extension has been requested by the member or by the Health Plan with the member's verbal permission.

A member or their authorized representative may file an expedited external review of an adverse determination without exhausting the Health Plan's internal appeal process under the following circumstances:

a. The time frame for completion of the internal appeal process would seriously jeopardize the life or health of the member or their ability to regain maximum function.
b. The adverse determination involves a denial of coverage based on the requested service or treatment being experimental or investigational and the treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.
c. Upon agreement by the Health Plan to waive the member's request for exhaustion of the internal appeal process requirement. If waived, the member or their authorized representative may file a request with the commissioner in writing for a standard external review.

C. Filing a request for external review

Except for expedited review requests, you or your AR shall request an external review with the Iowa Insurance Division. You or your AR will need to complete an External Review Request Form. This form can be obtained from the Iowa Insurance Division at:

330 Maple St.
Des Moines, IA 50319

Telephone: (877) 955-1212 or (515) 281-6348
Fax: (515) 281-3059
Website: www.iid.state.ia.us

A written request for an external review must be submitted within four months of our notice containing an adverse determination or a final adverse determination. You should submit your request for an external review to the Iowa Insurance Division at:

330 Maple St.
Des Moines, IA 50319
Telephone: (877) 955-1212 or (515) 281-6348
Fax: (515) 281-3059
E-Mail: market.regulation@iid.iowa.gov

When you or your AR files a request for an external review, you will be required to authorize the release of any medical records that may be required to conduct the external review. Your authorization can be provided by utilizing the External Review Request Form.

D. Standard External Request

Within five (5) business days of receipt of your external review request from the Iowa commissioner, we will complete a preliminary review to determine if the external request meets the following eligibility requirements:

- Evidence you were covered by the Plan at the time the service was proposed or received;
- Evidence the service is a covered benefit under your benefit plan, and based on a determination by us the proposed or received service or the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment being requested;
- Evidence that you or your AR provided all the information and forms required to process the external review request.

Within one (1) business day after completion of the preliminary review, we will notify the Iowa commissioner, you or your AR in writing if the request is complete and eligible for external review.

If we determine the request is not complete, we will notify you or your AR and the Iowa commissioner in writing that the request is not complete and what information and materials are needed to make the request complete.

If we determine the request is ineligible for an external review, we will issue a notice of initial determination in writing that will inform you or your AR and the

Iowa commissioner of the reason(s) why the request is ineligible for review and a statement informing you or your AR that the initial decision of ineligibility may be appealed to the Iowa commissioner. The Iowa commissioner may determine that a request is eligible for external review, even if we determined that the request was ineligible, and he or she may refer the request for external review.

Eligible External Review Request

Within one (1) business day after receipt of our notice of an eligible external review or upon the determination by the Iowa commissioner that a request is eligible for external review, the Iowa commissioner shall:

- Assign an external review organization (IRO) from the list of approved IROs maintained by the Iowa commissioner.
- Assign an IRO on a random basis among the list of approved IROs qualified to conduct a review based on the nature of the service of the adverse determination or final adverse determination.
- Provide written notification to you or your AR that the request was eligible and accepted for external review; the name of the assigned IRO, and that you or your AR may submit in writing to the IRO within five (5) business days following receipt of such notice from the Iowa commissioner, additional information the IRO shall consider when conducting the external review. The IRO may accept and may consider any additional information submitted by you or your AR after five (5) business days.

Within five (5) business days after receipt of notice from the Iowa commissioner of the assigned IRO, we will provide the assigned IRO all documents and information considered in making the adverse determination or final adverse determination.

The assigned IRO will review all the information and the documentation received from us and the information received in writing from you or your AR. Upon receipt of any additional information from you or your AR, the IRO within one (1) business day, will forward the information to us for review.

- Upon receipt of the additional information from the IRO, we may reconsider the adverse determination or the final adverse determination that is the subject of external review.
- Reconsideration by us will not delay or terminate the external review. The external review will only be terminated if we decide, upon completion of the reconsideration, to reverse the decision and to provide coverage or payment for the service or the treatment that is the subject of the adverse determination or the final adverse determination.

- Within one (1) business day after making a decision to reverse the adverse determination or the final adverse determination, we will notify you or your AR, the IRO, and the Iowa commissioner in writing of our decision.
- The IRO will inform the plan and you in writing of its decision within 45 days from the receipt of the request for review.

E. Expedited (Urgent Care) External Review

You or your AR can request an oral or a written external review with the Iowa commissioner when the following criteria are met:

- An adverse determination involves a medical condition in which the timeframe for completion of the internal appeal process would seriously jeopardize your life or health or your ability to regain maximum function.
- A final adverse determination that involves a medical condition in which the time frame for completion of the standard external review would seriously jeopardize your life or health or your ability to regain maximum function.
- A final adverse determination that concerns an admission, availability of care, a continued stay, or the services which the member received on an emergency basis, and has not been discharged from a facility.
- A final adverse determination that concerns a denial of coverage based on a decision that the recommended service or treatment is experimental or investigational, and your treating health care professional certifies in writing that the recommended service or the treatment would be significantly less effective if not promptly initiated.

Upon receipt of an expedited external review, the Iowa commissioner will immediately send written notification of the request to us. We will immediately complete a preliminary review to determine if the expedited external request meets the following eligibility requirements:

- Evidence you were covered by the Plan at the time the service was proposed or was received;
- Evidence the service is a covered benefit under your benefit plan, and based on a determination by us that the proposed or received service or treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
- Evidence you or your AR provided all the information and the forms required to process the external review request.

After our completion of the preliminary review, we will immediately notify the Iowa commissioner, you and your AR in writing if the request is complete and eligible for an external review. If we determine the request is not complete, then we will immediately notify you or your AR, and the Iowa commissioner in

writing that the request is not complete and what information and materials are needed to make the request complete.

If we determine the request is ineligible for an expedited external review, then we will immediately issue a notice of initial determination in writing informing you or your AR and the Iowa commissioner of the reason(s) why the request is not eligible for review and a statement informing you or your AR that our initial decision of ineligibility may be appealed to the Iowa commissioner. The Iowa commissioner may determine that a request is eligible for external review, even if we determined that the request was ineligible, and refer the request for external review.

Eligible Expedited External Review

Upon the receipt of an eligible external review or upon the determination by the Iowa commissioner that a request is eligible for expedited external review, the Iowa commissioner shall:

- Assign an IRO from the list of all approved IROs maintained by the Iowa commissioner and notify us, you or your AR of the name of the assigned IRO.
- Assign an IRO on a random basis among the list of approved IROs qualified to conduct the review based on the nature of the service of the adverse determination or final adverse determination.

Upon receipt of the notice from the Iowa commissioner of the assigned IRO, we will provide the assigned IRO all documents and all information considered in making our adverse determination or a final adverse determination.
The assigned IRO will then review all the information and the documentation received from us. Information received in writing from you or your AR will also be reviewed. Upon the receipt of additional information from the IRO, we may reconsider the adverse determination or the final adverse determination that is the subject of the external review.

- Reconsideration by us shall not delay or terminate the external review. The external review will only be terminated if we decide, upon completion of the reconsideration, to reverse the decision and provide coverage or payment for the service or treatment that is the subject of the adverse determination or final adverse determination.
- Within one (1) business day after making a decision to reverse the adverse determination or the final adverse determination, we will notify you or your AR, the IRO, and Iowa commissioner in writing of the decision. The IRO will terminate the external review upon receipt of our notice.

F. IRO Decision Time Frames for External Review

Standard

For standard external reviews, a decision will be made within 45 days after the IRO receives your request.

Expedited

If you have a medical condition that would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function if any treatment would be delayed, you may be entitled to request an expedited external review of our denial. A decision will be made within 72 hours after the IRO receives your request.

Upon receipt of the IRO's decision to reverse the adverse determination or the final adverse determination, we will immediately authorize coverage or provided payment of the services or treatment in dispute.

G. Effects of External Review Decisions

- The IRO review decision is binding on us and the findings of fact by the IRO are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts.
- We shall pay for costs of retaining the IRO to conduct the external review.
- We shall comply with the review IRO decision of the court on appeal.
- We and your treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the external review decision of the court on appeal.

SECTION 8 – COORDINATION OF BENEFITS

APPLICABILITY

Coordinating Medical Benefits:
Coordination of Benefits is defined as *a method of integrating benefits payable under more than one plan so that benefits from all sources do not exceed 100% of allowable expenses.*

We coordinate benefits with other insurance plans. The purpose of coordinating benefits is to control costs by reducing the benefits otherwise payable in certain situations under this Policy. Coordination of benefits occurs when you are covered under this Policy and:

1. Have other group insurance;
2. Are eligible for governmental programs or coverage required or provided by statute unless the law requires that this Policy is primary; or
3. Have liability coverage (i.e. automobile, home, or other liability), that has provided benefits for any healthcare costs related to the accident or injury.
4. This Policy is always secondary to Medicare for individuals who are eligible for Medicare for any reason.

A reduction in benefits will not apply if the benefits from all such plans, in total, do not exceed what is defined as an allowable expense. The definition of an allowable expense is*: a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.* Reductions will be made to the extent required to prevent benefits from exceeding the allowable expense.

Coordinating Pharmacy Benefits:
We will coordinate pharmacy benefits with other Insurance plans. When coordinating benefits as a secondary payer, in all circumstances you will be subject to the copayments, and to applicable coinsurance, under this Policy. Your copayment and/or applicable coinsurance under this Policy will apply to each prescription filled in a quantity not to exceed a 30-day supply or quantity limits established by us. If no payment was made by your primary insurance, we will process your claim and still apply your copayments and/or coinsurance according to your prescription benefits.

Prescription claims submitted for coordination of benefits (COB) by you will be processed and reimbursed through our Pharmacy Benefits Manager (PBM) at our current contracted rates. Contracted rates may be a lower amount than what you have paid for at your pharmacy. Any difference between the contracted rate and the amount you paid will be your responsibility.

Any current limitation on the medication submitted for coordination will apply, such as step therapy, a quantity level limit and any other formulary restrictions. Pharmacy benefit coordination will be consistent with this COB section, and will follow all provisions in relation to medical claim coordination of benefits.

ORDER OF BENEFIT DETERMINATION RULES

The order of benefit determination rules decides whether the benefits of this Policy apply before or after those of the other insurance plan.

A. **General.** When there is a basis for a claim under this Policy and another plan:
   1. This Policy is a secondary plan with benefits payable after those of the other insurance plan, unless:
      - The other plan has rules coordinating its benefits with those of this Policy; and
      - Both rules of the other insurance plan and this Policy require that this Policy's benefits be determined before those of the other insurance plan.
   2. The primary plan shall furnish or pay for all allowable services in accordance with the terms of such plan until those benefits are exhausted. Thereafter, if the benefits under a secondary plan are greater than under the primary plan, the secondary plan is responsible for further benefits until its benefits are exhausted;
   3. The order of the benefit determination rules do not apply to any insurance plan providing the benefits or the services pursuant to Workers' Compensation or similar laws, a no-fault automobile insurance act or similar law, or any Federal, state, or local government program, including Medicare. Such other insurance shall always be primary unless otherwise required by law; and
   4. If a person is covered by more than one secondary plan, the order of the benefit determination rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other insurance plan, which has its benefits determined before those of that secondary plan.

B. **Noncomplying Other Insurance Plans.** Except for services that are covered by Workers' Compensation, employer's liability insurance, Medicare, Medical Assistance, or traditional automobile "fault" contracts, we may coordinate the benefits of this Policy with a noncomplying other insurance plan.

   Benefits are coordinated as follows:
   1. If this Policy is primary, it will pay benefits first;

2. If this Policy is the secondary, it will pay its benefits first but the amount of the benefits payable will be determined as if this Policy were secondary. In such a situation, the payment will be the limit of this Policy's liability;
3. If the noncomplying other insurance plan does not provide the information we need to determine benefits within a reasonable time after we make the request, we will assume that the benefits of the noncomplying other insurance plan are identical to our own, and we will pay benefits accordingly. However, we will adjust any payments made whenever information becomes available as to the actual benefits of the noncomplying other insurance plan;
4. We will pay on your behalf an amount equal to the difference if the noncomplying other insurance plan reduces its benefits so that you receive less in benefits than you would have received had we paid benefits as secondary, and the noncomplying other insurance plan paid its benefits as primary; and
5. In no event shall we advance more than we would have paid had we been primary less any amount we had previously paid. In consideration of such advance, we shall be subrogated to all your rights against the noncomplying other insurance plan. Such advance by us shall also be without prejudice to any claim we may have against the noncomplying other insurance plan in the absence of such subrogation.

C. **Determination of Primary Coverage.** The following rules govern the determination of which plan is primary. The first applicable rule applies. If the other plan does not have the same determination of primary coverage provision, then the rules set forth in that other plan shall determine the order of benefits.
   1. **Non-Dependent/Dependent.** The benefits of the Policy that cover the person as a member are determined before those of the Policy that covers the person as a dependent;
   2. **Dependent Child/Parents Not Separated or Divorced.** The benefits of the Policy of the parent whose birthday (the day and month) occurs first during the calendar year are primary. If both parents have the same birthday, the benefits of the Policy that covered the parent longer is primary;
   3. **Dependent Child/Separated or Divorced Parents.** Custodial parent is defined as either the parent awarded custody of a child by a court decree, or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.
      a. If the parents are divorced, separated, or not living together, whether or not they have ever been married:
         - If a court decree states that one parent is responsible for the dependent child's benefits then that plan is primary;
         - If the parent with responsibility for health coverage does not have benefits for the dependent child, but the spouse of that parent does, then the plan of that parents spouse is the primary plan;

- If the court decree states both parents will be responsible for the dependent child, benefits should be coordinated according to item 2 above; or
- If the court decree states the parents have joint custody without specifying that one parent is responsible for the dependent child, benefits should be coordinated according to item 2 above.

b. If there is no court decree, responsibility of benefits is as follows.
- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and
- The plan covering the spouse of the non-custodial parent.

c. If the dependent child is covered under a Policy of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

4. **Active/Inactive Employee.** The benefits of a Policy that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent is primary. If the other insurance Policy does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored;
5. **Continuation Coverage.** If a person has continuation coverage under federal or state law and is also covered under another insurance plan, the benefits of a Policy covering the person as a member is primary, and the benefits under the continuation coverage is secondary. If the other Policy does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule shall not apply; and
6. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of the benefits, the benefits of the Policy that covered a person longer are primary.

EFFECT ON THE BENEFITS OF PLAN

A. **When This Section Applies.** This section applies when, in accordance with Order of Benefit Determination Rules, this Policy is a Secondary Plan. In that event, the benefits of this Policy may be reduced under this section.

B. **Reduction in Plan's Benefits.** The benefits of this Policy will be reduced when the sum of the benefits exceeds the covered services in a claim determination period. The definition of claim determination period is consistent with the benefit year. It does not include any part of a year during which a person was not covered under this Policy.

The sum of the benefits includes:

1. The benefits that would be payable for the covered services under this Policy in the absence of this coordination of benefits provision; and
2. The benefits that would be payable for the covered services under the Other Insurance Plans, in the absence of a coordination of benefits provision, whether or not a claim is made.

Under this provision, the benefits of this Policy will be reduced so that they and the benefits payable under the other insurance plans do not total more than the allowable expenses. When the benefits of this Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Policy.

C. **Payment as a Secondary Plan.** The amount by which a secondary plan's benefits are reduced shall be used by the secondary plan to pay covered services not otherwise paid which were incurred during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for covered services based on all claims that were submitted up to that point in time during the claim determination period.

RIGHT TO RECEIVE AND RELEASE INFORMATION

There is certain information needed to apply coordination of benefit rules. We may receive needed information from another organization without your consent, but only as needed to apply coordination of benefits rules. Medical records remain confidential as provided by state law. You must provide us any information we need to pay claims. If the requested information is not provided, we will not be able to process your claim.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. If you are eligible for Medicare benefits (Parts A and B), but not necessarily enrolled, your benefits under this Policy will be coordinated to the extent benefits otherwise would have been paid under Medicare as allowed by federal statutes and regulations. This policy is secondary to Medicare if you are eligible for Medicare for any reason.

FACILITY OF PAYMENT

A payment made by another insurance plan may include an amount that should have been paid under this Policy. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Policy. We will not have to pay that amount again. The term "payment made" or "amount of the payment made" means reasonable cash value of the benefits provided in the form of services.

SUBROGATION RECOVERY RIGHTS

The Plan has a right to subrogation and reimbursement.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.
  - You agree to notify us in writing in advance of a settlement with a third party that you or your dependents enter into which resolves a claim for which we have made payments. Your notice will include disclosure of all terms of the proposed settlement. You or your representative will not enter into any settlement without our prior written consent.
  - Failure to comply with the above terms shall be deemed prejudicial to our subrogation rights. We shall be entitled to seek a right of reimbursement against you for the full amount of the subrogation claim.
- We have a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral

source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

- Benefits paid by us may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the Benefits we have paid for the Sickness or Injury.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

WORKERS' COMPENSATION

No coverage is provided for treatment, services or supplies for any illness or injury arising out of, or in the course of, any activity for pay, profit or gain. This exclusion

applies regardless of whether benefits under Workers' Compensation or Occupational Disease laws have been claimed, paid, waived or compromised. This exclusion applies when an employer is required by the State of Iowa to provide Workers' Compensation coverage for employees. This includes the owner, and any family members who are employed and receiving wages.

This Policy is not issued in lieu of, nor does it affect, any requirement for coverage by Workers' Compensation. If you are eligible to receive Workers' Compensation for an injury or illness sustained in the course of any occupation or employment, that injury or illness is not covered under this Policy. However, if this Policy covers such bodily injury or illness, and we determine that you also received Workers' Compensation for the same incident, we have the right to recover as described under the Recovery Rights provision of the Coordination of Benefits Section. We will exercise the right to recover.

The recovery rights will be applied even though:
1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event that Workers' Compensation denied a claim, we will cover the resulting charges only if you have followed the guidelines outlined in this Policy. See Section 2: Access to Health Care for guidelines you must follow. You agree that, in consideration for the coverage provided by this COC, you will notify us of any Workers' Compensation claim made, and agree to reimburse us as described above. This provision shall also apply to coverage that you may receive under any Occupational Disease Act or law.

RIGHT OF RECOVERY

We are entitled to:
1. Determine whether, and to what extent, the other insurance plan provides benefits or services;
2. Determine which plan is primary;
3. Require that services or benefits be covered by the primary insurance plan. In the event we covered such services or benefits, and we were not primary, we will recover the reasonable value of services or benefits covered by us from the other insurance plan or the member; and
4. To process claims as the secondary payer.

If the amount of our payments is more than it should have been under this coordination of benefits provision, we may recover the excess payment from one or more of the following:

1. The member or dependent we have paid, or for whom payment was made
2. Insurance companies
3. Other organizations

You consent to the release of medical and/or legal information to us for you and your dependents when the enrollment form is signed. We have the right to deny any health care services or refuse to pay for the health services of any member who will not consent to release medical information to us.

You authorize and direct any person or institution that has examined or treated you to furnish to us at any reasonable time, upon our request, any and all information and records, or copies of records, relating to the examination or treatment rendered to you. We agree that such information and records will be considered confidential to the extent required by law. We shall have the right to submit any and all records concerning health care services rendered to you to appropriate medical review personnel.

SECTION 9 – GENERAL INFORMATION

CONSENT TO RELEASE INFORMATION

You consent to release to us medical and/or legal information for yourself and your dependents when you sign the Enrollment Form. We have the right to deny any health care services or refuse to pay for the health services if you will not consent to release to us medical information or other information that is necessary to pay a claim, coordinate benefits or exercise our right of reimbursement.

You authorize and direct any person or institution that has examined or treated you to furnish to us at any reasonable time, upon request, any and all information and records or copies of records relating to the examination or treatment rendered to you. We agree that such information and records will be considered confidential to the extent required by law. We have the right to submit any and all records concerning health care services rendered to you to appropriate medical review personnel.

ADVANCE DIRECTIVES

If you are over age 18 and of sound mind, you have the right to make decisions regarding your health care and medical treatment. Your decisions and wishes for medical treatment and health care can be spelled out in a document called an Advance Directive. You may also designate another person to make health care decisions on your behalf if you become mentally or physically unable to do so.

The Power of Attorney for Health Care appoints someone to make all health care decisions for you if you lose the ability to make these decisions for yourself. You may also include a description of your treatment preferences and special desires in this document, in order to guide the person making decisions for you. A Living Will describes the kind of life-sustaining care you would want if you had a life-threatening condition and were no longer able to communicate with those around you.

The decision to complete an Advance Directive takes thought, discussion and planning. We encourage you to discuss your questions and concerns regarding your future health care with your physician.

If you have questions or would like more information about Advance Directives, talk with your physician or contact:

Gundersen Medical Center
Pastoral Care
(608) 775-7300, ext. 53620 or (800) 362-9567, ext. 53620

Patient Services Representative:
(608) 775-7300, ext. 55993 or (800) 362-9567, ext. 55993

Advance Care Planning Coordinator
(608) 775-6000 or (800) 362-9567, ext. 56000

Gundersen Onalaska Clinic
Social Services
(608) 775-3454 or (800) 362-9567, ext. 53454

CONFORMITY WITH STATE STATUTES

Any provisions, which on the effective date of this Policy, are in conflict with the laws of the state in which this Policy is issued, are amended to conform to the minimum requirements of those laws.

INCONTESTABILITY

After you are insured for two years, we cannot contest the validity of coverage on the basis of any statement you made regarding your insurability. We cannot contest any statement made by you unless it is in a written form signed by you.

RESCISSION (IA INSURANCE CODE 514A.3)

We have the right to rescind coverage if a material misrepresentation was made on your application for insurance. To rescind means to cancel the insurance back to its effective date. A material misrepresentation is an untrue statement that leads us to insure you when we would not have done so under the terms, conditions and limitations of this Policy if we had known the truth. After coverage has been in effect for a period of two years, the right to rescind is no longer applicable. We will provide notice to members 30 days prior to the rescission of coverage.

ASSIGNMENT

Assignment of benefits may be made only with our consent. You assign benefits when you authorize us to pay your provider directly. An assignment is not binding until we receive and acknowledge in writing the original copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

CLERICAL ERROR OR MISSTATEMENT

If it is determined that information about you or your dependents was omitted or misstated in error, claims will be adjusted accordingly and a premium adjustment will be made. This provision applies equally to you and to us. If the error was determined after six months from the effective date of your coverage, no adjustment will be made.