Mail to Address

Member Name
Member ID
Job ID

Processed Date
Expected Mail Date
Actual Mail Date

MEMBER HANDBOOK FOR

HMO plans underwritten by Network Health Plan.
POS plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan.

Welcome to Network Health.

For over 30 years, we've been improving the health and well-being of our members. We started out small in 1982, organized by a group of Fox Valley doctors and have since earned a reputation for personal service and high quality. Today, we provide health insurance coverage to thousands throughout Wisconsin.

We offer a network that gives you access to more providers, doctors, hospitals and clinics. We realize the health care industry continues to evolve and it's more important than ever that we provide you with access to high-quality health care and doctors.

At Network Health, we offer you more than just health insurance. We're here to provide you with the tools you need to take care of your health and make good choices. Watch for our member magazine, *Balance*, to arrive in your mailbox. Each issue features inspirational stories from local members/participants like you. Inside you will find tips for healthy living, news on how we're advocating for the most efficient use of your health care dollars and updates on new services and programs.

Our mission is to enhance the life, health and wellness of the people we serve. When it comes to customer service, courtesy, respect and more, Network Health members rate us above average. We'll be here to answer your questions in plain language, because we understand how confusing health insurance can be. We promise to be more than a typical health plan and look forward to serving you.

TABLE OF CONTENTS

network health

KEWASKUM_SCHLS_18_3H2000

Coverage for: Individual or Individual + Family | **Plan Type:** HMO_SEWI

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-826-0940 or visit www.networkhealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.networkhealth.com or call 1-800-826-0940 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per Member / **$4,000** per Family	Generally, you must pay all of the costs from providers up to the Deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, immediate medical services and drugs are covered before you meet your deductible. See the specific services listed below denoted 'Deductible does not apply'.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$2,000** per Member / **$4,000** per Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See www.networkhealth.com or call Network Health Customer Service at 1-800-826-0940 for a listing of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Specialist visit	$35 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	Not Covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.networkhealth.com	Generic drugs (Tier 1)	$20 Copayment per Rx or refill retail or $55 Copayment per Rx or refill mail order	Not Covered	Covers up to a 31-day supply (retail prescription); 31-91 day supply (mail order prescription)
	Preferred brand drugs (Tier 2)	$40 Copayment per Rx or refill retail or $105 Copayment per Rx or refill mail order	Not Covered	Covers up to a 31-day supply (retail prescription); 31-91 day supply (mail order prescription)
	Non-preferred brand drugs (Tier 3)	$60 Copayment per Rx or refill retail or $180 Copayment per Rx or refill mail order	Not Covered	Covers up to a 31-day supply (retail prescription); 31-91 day supply (mail order prescription)
	Preferred Specialty drugs (Tier 4)	$60 Copayment per Rx or refill at specialty pharmacy and no mail order	Not Covered	Covers up to a 31-day supply (specialty pharmacy); No mail order
	Non-preferred Specialty drugs (Tier 5)	$100 Copayment per Rx or refill at specialty pharmacy and no mail order	Not Covered	Covers up to a 31-day supply (specialty pharmacy); No mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	Not Covered	----------None----------
	Physician/surgeon fees	0% Coinsurance	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 Copayment per visit; Deductible does not apply.	$250 Copayment per visit; Deductible does not apply.	Copayment waived if admitted inpatient within 24 hours
	Emergency medical transportation	0% Coinsurance	0% Coinsurance	----------None----------
	Urgent care	$75 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copayment per office visit; Deductible does not apply and 0% Coinsurance other outpatient services.	Not Covered	----------None----------
	Inpatient services	0% Coinsurance	Not Covered	----------None----------
If you are pregnant	Office visits	$20 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Childbirth/delivery professional services	0% Coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery facility services	0% Coinsurance	Not Covered	----------None----------
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	Not Covered	Limited to 50 Visits per 12 month period; Preauthorization is required.
	Rehabilitation services	$60 Copayment per visit; Deductible does not apply.	Not Covered	----------None----------
	Habilitation services	Not Covered	Not Covered	----------None----------
	Skilled nursing care	0% Coinsurance	Not Covered	Limited to 60 days per confinement period; Preauthorization is required
	Durable medical equipment	0% Coinsurance	Not Covered	----------None----------
	Hospice services	0% Coinsurance	Not Covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one Routine Eye exam per 12 months.
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Excluded service)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the Country
- Oral Surgery
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact Network Health Customer Service Department at 1-800-826-0940 for more information. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you may contact Network Health Customer Service Department at 1-800-826-0940 for more information.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum essential coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum value standard, you may be eligible for a Premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall Deductible	$2,000
Specialist Copay	$35
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall Deductible	$2,000
Specialist Copay	$35
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,840**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall Deductible	$2,000
Specialist Copay	$35
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$830
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,230**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-826-0940.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-826-0940.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-826-0940.

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-826-0940.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-826-0940 an.

Arabic:
إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول **Health Network**، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك. دون أي تكلفة. للتحدث مع مترجم 0940-826-800 فوري، قم باستدعاء

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-826-0940.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-826-0940.로 전화하십시오.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-826-0940.

Pennsylvania Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800-826-0940 uffrufe.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມຄໍາຖາມກ່ຽວກັບ Network Health, ທ່ານມ ສິດທ່ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 800-826-0940.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-826-0940.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800-826-0940.

Hindi: यदि आप, या किसी को आप की मदद कर रहे हैं, के बारे में सवाल है Network Health, आप कोई भी कीमत पर अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया के लिए बात करने के लिए, 800-826-0940 कहते हैं।.

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin
800-826-0940.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-826-0940.

Nondiscrimination

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Network Health's discrimination complaints coordinator at 800-826-0940.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Network Health's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 800-826-0940, TTY 800-947-3529, Fax 920-720-1907, compliance@networkhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's discrimination complaints coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

HMO COCHOICE PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This Summary reflects your Out-Of-Pocket expenses.

Non-covered services and denied Benefits will not apply to your Out-Of-Pocket Limit.

IN-NETWORK:	
Annual Deductible:	**$2,000 per Member and $4,000 per Family each Benefit year**
Member's Co-Insurance:	**0% of Eligible Expenses, unless otherwise specified**
Out-Of-Pocket Limit:	**$2,000 per Member and $4,000 per Family each Benefit year**

Medical & pharmacy Co-Payments and Deductible will apply to the Out-Of-Pocket Limit when the services are provided by a Network Health Plan Participating Provider.

This is a summary of your health care coverage.

All Benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

Please contact Network Health Plan's Customer Service Department at 1-800-826-0940 for assistance in understanding your health care Benefits.

Services	Benefits	Member Responsibility
Preventive Health	Please refer to your Member Handbook for a copy of the Preventive Services Guide document.	No Charge
	Routine Vision Exam	No Charge
Physician and Practitioner Services	Primary Care Practitioner Home & Office Visits *Including Behavioral Health & Substance Abuse*	$20 Co-Pay per visit
	Specialist Home & Office Visits	$35 Co-Pay per visit
	Virtual Visits	No Charge
	Primary Care Practitioner Inpatient Visits	No Charge
	Specialist Inpatient Visits	No Charge
	All other outpatient services/procedures performed in a Practitioner's office not otherwise listed on this table	Deductible
	Accidental Dental Services	$60 Co-Pay per visit
	Maternity Care	Deductible
	Chiropractic Office Visits & Manipulations	$20 Co-Pay per visit
	Medications administered in the Practitioner's office	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Chemotherapy Medication	Administered in the Practitioner's office, Outpatient Facility or in the home	Please refer to your Prescription Benefit Summary of Member Responsibility Table
Diagnostic Services	X-Ray, Lab, Pathology Practitioner's office or outpatient	Deductible
	Diagnostic Mammography Services Practitioners office or outpatient	Deductible
	PET Scans, MRIs, MRA's, CT Scans	Deductible
	Stress Tests	Deductible
	Ultrasounds/ Echocardiograms	Deductible
Hospital Services	Inpatient Services *Including Behavioral Health & Substance Abuse*	Deductible
	Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health & Substance Abuse*	Deductible
	Ambulatory Surgical Center	Deductible
Rehabilitation Services	Therapy – Physical/Occupational/Speech	$60 Co-Pay per visit
Home Health Care		Deductible
Hospice Care		Deductible
Durable Medical Equipment		Deductible

Services	Benefits	Member Responsibility
Medical Supplies	Including insulin pump supplies	Deductible
Ambulance Services	Land and Air	Deductible
Emergency/Urgent Care	Emergency Room Services (Co-Pay waived if admitted inpatient within 24 hours) Urgent Care	$250 Co-Pay per visit $75 Co-Pay per visit
Health Education Programs	Please refer to Certificate of Coverage for list of Benefits & limitations	No Charge
Diabetic Supplies	Please refer to the Prescription Benefit Summary of Member Responsibility Table	
Prescription Drugs:	Please see the Prescription Benefit Summary of Member Responsibility Table for prescription drug information, including medications administered in the Office or Outpatient setting.	

network health

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- Headache
- Insect bites
- Nausea and vomiting
- Pink eye
- Rash
- Respiratory problems
- Sore throats
- Urinary problems or UTI
- Vaginitis
- And more

e-prescriptions can be sent to your local pharmacy (if needed).

Don't procrastinate.
ACTIVATE

Access MDLIVE by logging in to **networkhealth.com/MyAccount** clicking on the MDLIVE Virtual Visits link. Sign in to your MDLIVE account to see what you'll pay for virtual visits. **877-958-5455**

MD Download the MDLIVE App

MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeu-tic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE interactive audio consultations with store and forward technology are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/pages/terms.html 120115

HMO plans underwritten by Network Health Plan. POS Plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan. Self-funded plans administered by Network Health Administrative Services, LLC.

SAL-378-01-11/16

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If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-826-0940.
Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-826-0940.
Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-826-0940.

network health

PREVENTIVE SERVICES GUIDE

To help you live the healthiest life possible, Network Health offers preventive services at no cost for most of our members.

Your annual wellness visit, which consists of a general review of your health and well-being, is considered preventive, and covered by Network Health at no charge when you visit a doctor within our provider network.

** Network Health follows the recommendations of the United States Preventive Services Task Force (USPSTF). USPSTF recommendations are posted on networkhealth.com.*

Services offered once a year unless otherwise noted.

Preventive Coverage

Children's Health (Newborn through age 18)

WELL-CHILD VISITS	
AGE	**RECOMMENDATION**
Newborn	One visit 3-5 days after discharge
0-2 years	One visit at 2, 4, 6, 9, 12, 15, 18 and 24 months old
3-6 years	One visit at 30 months and one visit every year for ages 3-6
7-10 years	One visit every 1-2 years
11-18 years	One visit every year

IMMUNIZATIONS	
VACCINE	**RECOMMENDATION**
Chickenpox (varicella)	Two total doses, one dose at 12-15 months old and one dose at 4-6 years old. Adolescents 14 and older with no history of vaccination or disease may receive two doses 4-8 weeks apart.
Diphtheria, tetanus, whooping cough (pertussis)	Four total doses of DTaP, one dose at 2 months, one dose at 4 months, one dose at 6 months and one dose at 18 months. One dose of Tdap between 11-12 years old with a Td booster every 10 years after. Those older than 7 years and not previously immunized can get a single dose of Tdap.
Flu (influenza)	Two total doses 4 weeks apart for healthy children between 6 months and 8 years old first time they get the vaccine. Children who've previously had the flu shot and those over 8 years old can receive one dose annually.
Haemophilus influenza type b	Four total doses, one dose at 2 months, one dose at 4 months, one dose at 6 months and one dose between 12-18 months old.
Hepatitis A	Two total doses at least 6 months apart between 12-23 months old. For children not immunized as a baby, two doses can be given at a later age at least 6 months apart.
Hepatitis B	Three doses total, one dose to all newborns before leaving the hospital, one dose between 1-2 months and one dose between 6-18 months. Series may be given between 2-18 years old if not immunized as a baby.
HPV (human papillomavirus)	Three doses over a 24-week period starting at 11 years old for boys and girls. Your doctor may give the vaccine as early as age 9 if child is at higher risk.
Polio	Four total doses, one dose at 1 month, one dose at 2 months, one dose at 4 months, one dose between 16-18 months, and one dose between 4-6 years old.
Measles, mumps, rubella (MMR)	Two total doses, one dose between 12-15 months and one dose between 4-6 years old. Can be given to older children if no history of vaccination or the disease.
Meningitis (meningococcal)	Two doses total, one dose between 11-12 years, and one dose at 16 years old. If the first dose is given between 13-15 years, then the second dose should be given between 16-18 years old. Doctors may give vaccine as early as age 2 to children at higher risk.
Pneumonia (Pneumococcal)	Four doses total, one dose at 2 months, one dose at 4 months, one dose at 6 months and one dose at 12-15 months old. Children over 2 years old can get a single dose if not previously immunized. Children with underlying medical conditions can receive an additional dose. Children at higher risk can be vaccinated after age 7
Rotavirus	Three doses total, one dose at 2 months, one dose at 4 months and one dose at 6 months old.

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See reverse side

Children's Health (Newborn through age 18)

DOCTOR VISITS AND TESTS	
ASSESSMENTS, SCREENINGS AND COUNSELING	**RECOMMENDATION**
Alcohol and drug use	Assessment for adolescents during well-child visits.
Autism	Screening for children during well-child visits.
Behavioral Assessment	Screening for children during well-child visits.
Blood pressure	Screening for children during well-child visits.
Cavity prevention	Flouride application starting at age of primary tooth eruption, up to 5 years old.
Depression Screening	Screening and assessment during well-child visits at 12-18 years old.
Developmental	Screening for children during well-child visits.
Dyslipidemia	Screening for children at high risk ages: 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Hearing loss	Screening for all newborns. Annual screening for children age 6 years and older.
Height, weight and body mass percentile	Screening for children during well-child visits.
Hematocrit or hemoglobin	Screening for all children around 12 months, other ages if indicated.
Hemoglobinopathies	Screening for sickle cell disease in newborns.
Hepatitis B	Annual screening for adolescents at higher risk.
HIV screening	Annual screening for adolescents ages 15 to 18 years. Screening for younger adolescents at increased risk.
Hypothyroidism	Screening for newborns.
Lead	Annual screening for children at risk of exposure.
Medical history	Reviewed during well-child visits.
Obesity screening	Screening for children age 6 years and older during well-child visits. Behavioral interventions for those at increased risk.
Oral health	Risk assessment for children ages 0-11 months, 1-4 years, 5-10 years during well-child visits.
Phenylketonuria screening	Screening for newborns.
Sexually transmitted infections	Prevention counseling and screening for adolescents at higher risk.
Skin cancer behavioral counseling	Counseling during well-child visits for children, adolescents and young adults ages 10-24 years with fair skin.
Tobacco use	Screening and counseling during well-child visits for school-aged children and adolescents.
Tuberculosis screening	Screening for children at higher risk ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years.
Vision	Screening for all children at least once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
Visual acuity screening	Annual screening for children under age 18 years.
DRUGS	
PRESCRIPTIONS	**RECOMMENDATION**
Gonorrhea preventive	Ocular topical medication for all newborns
Iron Supplements	Children ages 6-12 months at risk for anemia
Oral fluoride supplements	Children 6 months-5 years old without fluoride in their water source.

Adult Health (Care for all Adults)

PHYSICAL EXAMS	
AGE	**RECOMMENDATION**
19-21 years	Once every 2–3 years; annually if desired
22-64 years	Once every 1–3 years
65 and older	Once every year
IMMUNIZATIONS *(Doses, ages and recommendations vary)*	
VACCINE	**RECOMMENDATION**
Chickenpox (varicella)	Two total doses 4 weeks apart for those with no history of the vaccination or disease
Flu (influenza)	One dose every year
Hepatitis A	Two doses for those at high risk not previously vaccinated

Adult Health (Care for all Adults)

IMMUNIZATIONS *(Doses, ages and recommendations vary)*	
VACCINE	**RECOMMENDATION**
Hepatitis B	Three doses for those at high risk not previously vaccinated
HPV (human papillomavirus)	Three total doses over a 24–week period up to age 21 for men, up to age 26 for women if not previously vaccinated.
Measles, mumps, rubella (MMR)	One to two total doses if no history of the vaccination or disease. Can be given after age 40 if at high risk.
Meningitis (meningococcal)	One dose for ages 19 – 24 if no history of vaccination. Can be given after age 40 if at high risk.
Pneumonia (Pneumococcal)	One dose of PCV13 and 1 dose of PPSV23 after age 65, depending on age and health conditions.
Shingles (herpes zoster)	One dose for those 60 and older.
Tetanus, diphtheria and whooping cough (pertussis)	One dose of Tdap if not previously given pertussis vaccine, followed by a Td booster every 10 years.
DOCTOR VISITS AND TESTS	
ASSESSMENTS, SCREENINGS AND COUNSELING	**RECOMMENDATION**
Abdominal aortic aneurysm screening	One time screening for men ages 65 – 75 with a history of smoking.
Alcohol misuse screening and counseling	Screening for all adults age 18 years and older. Behavioral counseling for those engaged in risky behavior.
Blood pressure screening	During physical exam
Cholesterol screening	Annual screening for adults ages 40-75.
Colorectal cancer screening	For those ages 50 – 75, one of the following screenings: • Colonoscopy every 10 years • CT colonography every 5 years • Flexible sigmoidoscopy every 5 years • FIT every year • gFOBT every year
Depression screening	Annual screening for adults.
Diabetes screening	Annually for adults ages 40-70 at higher risk due to weight and CVD risk.
Diet and physical activity counseling	Behavioral counseling for overweight adults with additional cardiovascular disease risk factors.
Falls prevention: exercise or physical therapy	Exercise or physical therapy to prevent falls in community-dwelling adults age 65 and older at increased risk for falls.
Hepatitis B screening	Annual screening for adults at high risk.
Hepatitis C screening	Annually for adults at high risk and a one-time screening for adults born between 1945
HIV screening	Annual screening for adults up to age 65. Screen older adults if at high risk.
Lung cancer screening	Annual screening with low-dose computed tomography for adults ages 55 to 80 who have a 30-pack/year smoking history and currently smoke or quit within the past 15 years.
Obesity screening and counseling	Screening for all adults during wellness visits, behavioral interventions for those with a body mass index of 30kg/m2 or higher.
Sexually transmitted infection (STI) counseling	Behavioral counseling for all sexually active adults who are at increased risk for sexually transmitted infections.
Syphilis screening	Annual screening for adults at increased risk.
Tobacco counseling and interventions	Screening of all adults during wellness visits. Advise to stop and cessation interventions for adults who use tobacco.
Tuberculosis testing	Screening for adults at increased risk.
Vision	Screening (unless directly excluded from your policy).
DRUGS *(Prescription Required)*	
PRESCRIPTION	**RECOMMENDATION**
Low–dose aspirin therapy to prevent heart disease	Age 50-59 with increased risk of cardiovascular risk.
Statin preventive medications	Adults ages 40 to 75 with CVD risk factors with an increased risk of having a cardiovascular event.
Tobacco cessation products	US FDA approved pharmacotherapy for cessation.
Vitamin D supplement	Vitamin D2 or Vitamin D3 (with or without calcium) containing 1,000 IU or less for adults age 65 and older who are at increased risk for falls.

Women's Health (See the "Adult health" section for recommended care for all adults)

DOCTOR VISITS AND TESTS	
ASSESSMENTS, SCREENINGS AND COUNSELING	**RECOMMENDATION**
Anemia screening	Screening for pregnant women or women who may become pregnant.
BRCA risk assessment and	Risk assessments for women with a family history of breast, ovarian, tubal or peritoneal cancer. Women who test positive should receive genetic counseling and, if indicated after counseling, BRCA testing (1 time).
Breast cancer screening	Every 1-2 years for women 40 years and over.
Chlamydia screening	Annual screening for sexually active women age 24 years and and younger and in older women at increased risk.
Contraceptive counseling and contraception methods	FDA–approved contraceptive methods, sterilization procedures, education and counseling.
Gonorrhea screening	Annual screening for sexually active women 24 and under and in older women at increased risk.
Intimate partner violence screening and counseling	Screening for women of childbearing age and intervention for those who screen positive.
Osteoporosis screening	Screening for women age 65 and older. Younger women who are at high risk.
Pap and HPV test (cervical cancer screening)	Age 21-65 cytology (pap) every 3 years, or for those age 30-65 who wish to lengthen screening interval, pap and HPV every 5 years.
DRUGS *(Prescription Required)*	
PRESCRIPTION	**RECOMMENDATION**
Breast cancer prevention medication	Approved risk reducing medications for women at increased risk for breast cancer and low risk for adverse medication effects.
Folic acid supplements	Women who are planning or capable of becoming pregnant.
CONTRACEPTIVES *(Prescription Required)*	
TYPE	**METHOD**
Contraceptives	Approved contraceptive methods (implantable and injectable); generic when available
Permanent	Sterilization

Pregnant Women's Health

DOCTOR VISITS AND TESTS	
ASSESSMENTS, SCREENINGS AND COUNSELING	**RECOMMENDATION**
Anemia screening	Screening for pregnant women.
Bacteriuria screening	Screening for pregnant women at 12 to 16 weeks gestation or during first prenatal visit if later.
Breastfeeding support, supplies and counseling	Interventions before pregnancy and after birth to support breastfeeding.
Gestational diabetes screening	Screening for pregnant women after 24 weeks of gestation.
Hepatitis B screening	Screening during the first prenatal visit.
HIV screening	Screening for all pregnant women.
Preeclampsia screening	Screening in pregnant women with blood pressure measurements throughout.
Rh incompatibility screening: first pregnancy visit	Rh(D) blood typing and antibody testing for all pregnant women during their first pregnancy related visit.
Rh incompatibility screening: 24/28 weeks' gestation	Repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24-28 weeks' gestation, unless biological father is known to be Rh(D)-negative.
Syphilis screening	Screening for all pregnant women.
DRUGS *(Prescription Required)*	
PRESCRIPTION	**RECOMMENDATION**
Low-dose aspirin therapy	After 12 weeks of gestation for pregnant women who are at risk for preeclampsia.

1570 MIDWAY PLACE
P.O. BOX 120
MENASHA, WI 54952
920-720-1300 OR 1-800-826-0940

Network Health Plan (NHP) has entered into a health services policy (Policy) with Your Employer to provide You with a health care benefit program. NHP has issued and delivered the Policy to Your Employer. You may ask Your Employer for a copy of the Policy.

In the event Your Employer wishes to purchase a Point-of-Service (POS) Plan Rider in conjunction with the Policy, NHP and Network Health Insurance Corporation (NHIC) will enter into an agreement with Your Employer to provide a POS health care benefit program.

This is Your Certificate of Coverage (Certificate) as long as You are eligible for insurance and You become and remain insured. This Certificate explains the terms and conditions of Your insurance coverage.

READ THIS CERTIFICATE OF COVERAGE CAREFULLY.

The Policy, Certificate, Summary of Member Responsibility Table/Summary of Benefits and Coverage, and any applicable Riders and/or Amendments describe in detail Your coverage and the eligibility, Effective Date of coverage, continuation, and termination rules. A Family Planning Rider which describes Your family planning health care Benefits is included with the Policy and this Certificate.

The terms and conditions of Your coverage may change from time to time. NHP may modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. You or Your Employer will receive written notice of any changes in these documents. If there is a conflict between this Certificate and any summaries provided to You by the Group, this Certificate will control. If You have questions, please contact Your Employer's Insurance Administrator or NHP's Customer Service Department at the address or telephone number listed above.

This Certificate replaces any previous Certificate that You may have been issued and becomes effective in accordance with the terms of Your Employer's Policy with NHP.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Wisconsin. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Wisconsin are the laws that govern the Policy.

INFORMATION ABOUT DEFINED TERMS

Because this Certificate is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Article XII: Defined Terms. You can refer to Article XII: Defined Terms as You read this document to have a clearer understanding of Your Certificate.

When We use the words "We," "Us," and "Our" in this document, We are referring to Network Health Plan. When We use the words "You" and "Your," We are referring to people who are Members, as that term is defined in Article XII: Defined Terms.

IMPORTANT NOTICE

Please read the copy of the enrollment form which has been previously delivered to You by the Group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid Claim to be denied. Carefully check the enrollment form and write to NHP within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

This Certificate provides coverage for Medically Necessary Emergency Health Services and Urgent Care services. For Urgent Care services received from a Non-Participating Provider or a Non-Participating Practitioner outside of a Hospital facility, You must notify NHP within 48 hours or on the next business day of receiving the Urgent Care service for coverage.

If You incur non-covered expenses, You are responsible for making the full payment to the health care provider. The fact that a healthcare Practitioner has performed or prescribed a medically necessary procedure, treatment, or supply, or the fact that it may be the only available treatment for a Bodily Injury or Illness, does not mean that the procedure, treatment or supply is covered under this Certificate.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES:

As a Member of Network Health Plan (NHP) You have certain rights and responsibilities. Network Health Plan is committed to providing You with services that respect Your rights. Your Member, handbook and Certificate of Coverage contain important information regarding Your Benefits, rights and responsibilities, which include but are not limited to the following:

MEMBER RIGHTS…

1. Members have a right to receive information about the managed care organization, its services, its Practitioners and providers, and Members' rights and responsibilities.
2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.
3. Members have a right to participate with Practitioners in decision making regarding their health care.
4. Members have a right to a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.
5. Members have a right to voice Complaints or appeals about the managed care organization, the care provided and/or the use and disclosure of protected health information.
6. Members have a right to select a Primary Care Practitioner and to change for any reason.
7. Members have the right to review their medical records with their Primary Care Practitioner.
8. Members have the right to receive prompt and courteous service from representatives regarding benefit interpretations, eligibility information, Claims inquiries or other related matters when contacting Network Health Plan/Network Health Insurance Corporation.
9. Members have the right to be informed of their diagnosis, treatment and prognosis from their Practitioner in terms they understand.
10. Members have the right to refuse treatment and to be informed of the probable consequences of their actions.
11. Members have the right to make recommendations regarding the organizations Members' rights and responsibilities.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RESPONSIBILITIES…

1. Members are responsible to communicate openly with Practitioners or health plan personnel. If members have questions with their treatment plan, they have the responsibility to discuss their concerns and make certain they understand the Practitioner's explanation and instructions.
2. Members are responsible to read and understand their Benefits as outlined in their Summary of Members Responsibility Table/Summary of Benefits and Coverage and Certificate of Coverage.
3. Members are responsible to follow the established policies and procedures set forth by NHP as outlined in Your Certificate of Coverage.
4. Members are responsible to follow the plans and instructions for care that they have agreed on with their Practitioners.
5. Members are responsible to treat all Providers or health plan personnel respectfully and courteously.
6. Members are responsible to provide, to the extent possible, information that the managed care organization and its Practitioners and Providers need in order to care for them.
7. A Member has the responsibility to notify his or her health care provider(s) and NHP of changes in insurance coverage, eligibility, address or phone number.
8. A Member has the responsibility to keep scheduled appointments or give adequate notice of delay or cancellation.
9. A Member has the responsibility to constructively express his or her concerns or dissatisfaction regarding NHP or their health care provider so that We can rectify the situation.
10. A Member has the responsibility to participate in understanding his or her health problems and developing mutually agreed upon treatment goals.
11. A Member is responsible for knowing which providers are in network prior to accessing services. The on-line website is the most up-to-date source for this information.
12. A Member is responsible for obtaining an Authorization from Network Health Utilization Management for any services he or she wishes to obtain from non-participating Practitioners and Providers.

GENERAL PROVISIONS

Table of Contents

GENERAL PROVISIONS

GENERAL PROVISIONS

ARTICLE I ~ GENERAL PROVISIONS

1) CERTIFICATE ADMINISTRATION

NHP will administer, interpret, and apply the Certificate of Coverage (Certificate) to provide a fair application of its terms to all Members. NHP may adopt, interpret, and apply any rules necessary to administer this Certificate. NHP does not require Group or Member consent for adopting, interpreting, or applying these rules. Any action or decision issued by NHP will be conclusive and binding on all persons, except as otherwise provided in the Certificate. (See Article X, Complaint & Grievance Resolution Process). NHP may subcontract the administration of all or part of this Certificate and Your Benefits to a third party.

2) NHP IDENTIFICATION (ID) CARDS

NHP ID cards are for identification purposes only. An individual must be a NHP Member to receive services or Benefits. An individual is not entitled to NHP Benefits because s/he has a NHP ID card. NHP may revoke coverage of a Member who allows unauthorized use of a NHP ID card.

3) WAIVER

Only NHP may waive any term or provision of this Certificate. NHP will only do so in writing. Only an authorized employee, agent, or representative of NHP may sign such written waiver. No oral representation of any employee, agent, or representative of NHP is sufficient to waive, modify, or amend any term or provision of this Certificate.

4) NON-DISCRIMINATION

NHP will not discriminate in violation of state or federal law in denying membership to any eligible Primary Insured or Dependent. NHP will not discriminate in violation of any State or Federal law in administering Benefits.

5) RIGHT TO EXCHANGE INFORMATION

NHP may obtain and provide to any person or organization all medical information and records necessary to administer NHP Benefits.

> ***IMPORTANT:*** *NHP will use and disclose confidential medical and patient information only as allowed by State and Federal law.*

6) PHYSICAL EXAMINATION

At NHP's request, Member must submit to a physical exam for purposes of:

a) Determining Member eligibility for claimed services and benefits, and
b) Recovery rights (See ARTICLE VII ~ RECOVERY RIGHTS)

Such exam will be at NHP's expense. Each Member or Member's representative waives all rights to refuse consent for such examination.

7) GOVERNING LAW AND LEGAL ACTIONS

No person may bring a legal action arising out of or relating to this Certificate until the earliest of:

a) Sixty (60) Days after written proof of loss is provided.
b) Sixty (60) Days after written proof of loss is required to be provided.
c) NHP waives the need for such proof of loss in writing.
d) NHP's denial of payment.

No person may bring legal action more than three years after the earliest of these dates.

NHP delivered this Certificate in Wisconsin. The laws of Wisconsin govern this Certificate. To the extent that Employee Retirement Income Security Act (ERISA) or any other Federal law pre-empts Wisconsin law, this Certificate will be construed under such law.

8) CLERICAL ERRORS

Verbal or written clerical errors will not change the rights or obligations of any party under this Certificate.

9) HEADINGS

The use of titles, headings or sections is for the parties' convenience and carries no weight in interpreting this Certificate.

10) PROOF OF LOSS

NHP will accept only Claims that are in English. All Claims must be in writing. Claims must be submitted within ninety (90) Days of service. When NHP is the secondary payer, coordination of benefits must be submitted to NHP within ninety (90) Days after receipt of the primary payer's explanation of benefits. If it is not reasonably possible for You to submit Your Claim within the ninety (90) Days, NHP will still accept Your Claim until one year after the ninety (90) Days.

11) NON-PARTICIPATING PROVIDER AND NON-PARTICIPATING PRACTITIONER COVERAGE

Except for Emergency Health Services and Urgent Care Services received in a Hospital, if You wish to receive coverage for services from a Non-Participating Provider or a Non-Participating Practitioner, You must obtain Prior Authorization from NHP. If You choose to receive non-Emergency Health Services or non-Urgent Care from a Non-Participating Provider, you will be responsible for the cost of the Non-Participating Provider's charge for such services. Because NHP does not have an agreement with Non-Participating Providers, this cost may be significant. Please call Customer Service Department or log on to networkhealth.com to make sure your provider is a Participating Provider.

If You are admitted to a Non-Participating facility following Emergency services or if You receive Urgent services from a Non-Participating, non-hospital facility, You must notify NHP within forty-eight (48) hours or the next business day of Your admission or service. If You are incapable of providing notice within that time, You must provide notice within forty-eight (48) hours or the next business day of regaining capability. A Member is not capable of providing

11) NON-PARTICIPATING PROVIDER AND NON-PARTICIPATING PRACTITIONER COVERAGE (continued)

notice only if physically or mentally unable to personally provide notice and unable to provide notice through another person. A minor's parent or guardian must provide notice to NHP within forty-eight (48) hours or the next business day of the minor's admission to a Non-Participating facility following Emergency services. If the parent or guardian is not aware of the minor's admission, the parent or guardian must notify NHP within forty-eight (48) hours or the next business day of becoming aware of the admission.

A Maximum Out-of-Network Allowable Fee may be applied when services are received from a Non-Participating Provider or Non-Participating Practitioner Provider.

12) NON-WAIVER AND SEVERABILITY

NHP's delay or failure to exercise a remedy or right under this Certificate will not impair or waive NHP's remedies or rights or affect any subsequent remedy or right NHP may have.

A finding that a Certificate provision is unenforceable or invalid for any person or circumstance will not make the provision unenforceable or invalid for any other person or circumstance. An unenforceable or invalid Certificate provision will not make the remainder of this Certificate invalid or unenforceable.

13) CONTINUITY OF CARE

NHP will protect the continuity of care You receive from Practitioners NHP lists as participants in its network during Your open enrollment or employer renewal period if:

A. Primary Care Practitioner (PCP)

The Practitioner is Your PCP. NHP will treat Your PCP as a Participating Practitioner for a minimum of ninety (90) Days or until Your employer's next renewal date, whichever is longer. This is the case even if the PCP is no longer in NHP's network.

B. Specialty Care Practitioner (SCP)

You are undergoing a current course of treatment with a SCP and Your SCP's relationship with NHP ends. NHP will treat Your SCP as a Participating Practitioner for up to 90 Days after the end of the SCP's relationship with NHP.

C. Obstetric Care Practitioners (OCP)

You are pregnant, in Your second or third trimester (the second trimester starts at 13 Weeks gestation), and Your OCP's relationship with NHP ends. NHP will treat Your OCP as a Participating Practitioner for treatment provided to You and the infant(s) through post-partum care.

IMPORTANT: *These provisions do not apply to a Practitioner terminated for professional misconduct or one who stops practicing in NHP's Service Area.*

14) INITIAL CLAIMS

NHP processes Claims according to applicable State and Federal time frames. Your Providers will file most Claims. When You personally file a Claim, You must provide all information reasonably necessary to process the Claim. This will help NHP process Your Claim quickly. Questions about benefits, eligibility or the circumstances under which NHP pays benefits are not Claims. For example, a question about whether Your spouse is eligible for a particular treatment is not a Claim.

15) PAYMENT

NHP pays medical insurance benefits (after satisfaction of the Annual Deductible), subject to all of the terms, conditions, limitations and exclusions of this Certificate of Coverage and any other Riders and/or Amendments attached to the Policy. All covered health care benefits provided are subject to a Member paid Co-Payment and/or Co-Insurance and/or Deductible and/or Out-of - Pocket Limit as specified in the Summary of Member Responsibility Table/Summary of Benefits and Coverage.

16) WORKERS' COMPENSATION (WC)

NHP does not issue this Certificate in lieu of WC Coverage. This Certificate does not affect any WC coverage requirements. NHP will not cover health services for job, employment, or work related Bodily Injuries or Illnesses for which coverage is required under any WC policy, Occupational Disease Act or law. NHP has the right to recover payments it makes for such health services. NHP may recover its payments as described in the Recovery Rights provisions of ARTICLE VII ~ RECOVERY RIGHTS. As a condition to NHP's payment for services for which NHP might not be liable under this section, Member consents to reimburse NHP when entering into any WC settlement or compromise or at any WC Division Hearing. NHP reserves the right to recover such payments from the Member, even though:

a) The WC benefits are disputed or are obtained through settlement or compromise;
b) No final decision is made that the Bodily Injury or Illness took place in the course of or resulted from employment;
c) The Member or the WC carrier disputes the amount of WC due or the amount is not defined; or
d) The WC settlement or compromise excludes medical or health care benefits.

No Member may enter into a compromise or hold harmless agreement relating to NHP's paid Claims without NHP's express written consent. This is the case whether the WC insurer disputes such Claims or not.

17) COOPERATION

Each Member claiming benefits under this Plan must give Us any facts We need to determine benefits payable. If You do not provide Us the information, Your Claim for benefits may be denied.

ARTICLE II ~ BENEFIT PROVISIONS

1) SCHEDULE OF BENEFITS

NHP will cover health products and services set forth in this Article and any applicable Riders. NHP's coverage is subject to Member cost sharing set forth in the Summary of Member Responsibility Table/Summary of Benefits and Coverage. Coverage for all health products and services are subject to the exclusions and limitations of this Certificate.

2) GENERAL BENEFITS PROVISION

NHP will cover Medically Necessary health services that are for the prevention, diagnosis, or treatment of a Bodily Injury or Illness. NHP will cover only services that are appropriate, as set forth in this Certificate.

Your Practitioner or an authorized Provider is responsible for requesting an Authorization for services with Participating Practitioners and Providers requiring Authorization. You are responsible for requesting Authorization for services with Non-Participating Practitioners and Non-Participating Providers.

A Member's Practitioner, or PCP, is responsible for that Member's care.

> ***IMPORTANT:*** *NHP must receive and approve all non-urgent, non-emergent Authorization requests prior to the services being furnished.*
>
> ***IMPORTANT:*** *The fact that NHP may cover evaluation for diagnosis does not imply coverage for resulting care or treatment. Benefit limitations and exclusions will apply.*
>
> ***IMPORTANT:*** *The fact that a Practitioner refers You or a covered Dependent for services or treatment does not mean or imply that NHP will cover the services or treatment.*

Please refer to ARTICLE III ~ OBTAINING HEALTH SERVICES for information and requirements on obtaining benefits under this Certificate.

NHP may identify service improvement opportunities. In these situations, NHP may offer You service improvement items of limited value. Any service improvement item provided to You is subject to compliance with applicable Federal and State law, and will be documented by NHP in writing.

3) AMBULANCE SERVICES

NHP will cover ground or air ambulance transport for Emergency conditions. NHP will only pay for transport to the nearest facility that can furnish Emergency Health Services. NHP will cover non-emergency transfer ambulance service that it initiates without Member cost sharing.

Non-Covered Ambulance Services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Non-Emergency transport, unless initiated by NHP.

3) AMBULANCE SERVICES (continued)

b) Services or supplies that are not Medically Necessary, even if furnished while in transport.

4) AUTISM SERVICES

NHP will cover the treatment for the primary, verified diagnosis of Autism Spectrum Disorder if the treatment is evidence-based and prescribed and rendered by a Practitioner who is qualified to provide intensive-level or nonintensive-level services.

IMPORTANT: *This coverage is subject to Deductibles, Co-Insurance, or Co-Payments that generally apply to other conditions covered under this Certificate.*

IMPORTANT: *Prescription medications and Durable Medical Equipment (DME) will not count toward the coverage limits.*

Intensive-level Services:
NHP will provide coverage of at least $60,158, at the time of this printing, for evidence-based behavioral intensive-level services per Member per year, with the Member receiving at least 20 hours of therapy per week over a continuous six-month period of time for up to forty-eight (48) months. The forty-eight (48) months of intensive-level treatment will be treated as a cumulative amount. For example, a child who received twenty-four (24) months of intensive-level treatment under another insurer or the Medicaid waiver program would be entitled to another twenty-four (24) months of treatment under NHP.

IMPORTANT: *The intensive-level services must begin after a Member is two (2) years of age and before the Member is nine (9) years of age.*

Nonintensive-level Services:
NHP will provide coverage of at least $30,079, at the time of this printing, for evidence-based behavioral non-intensive-level services per Member per year.

IMPORTANT: *Nonintensive-level services must sustain and maximize gains made during intensive-level treatment or improve the Member's condition.*

Non-Covered Autism Services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Acupuncture
b) Respite Care,
c) Custodial Care,
d) Care provided in a residential treatment facility, inpatient treatment, or day treatment facility,
e) Chelation Therapy,
f) Child care fees,
g) Cranial Sacral Therapy,
h) Hyperbaric Oxygen Therapy,

4) AUTISM SERVICES (continued)

i) Special diets or supplements,
j) Auditory Integration Training,
k) Facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of a Member home,
l) Services rendered by any Practitioner who is not qualified to provide intensive-level services or non-intensive level services, and
m) Animal-based therapy including equine therapy and hippotherapy.

5) BREAST RECONSTRUCTION

NHP will cover breast reconstruction related to a mastectomy. NHP will pay for:

a) Reconstruction of the breast on which the mastectomy was performed.
b) Surgery and reconstruction of the other breast to produce an even appearance.
c) Prosthesis and treatment of physical complications at all stages of the mastectomy.

6) CARDIAC REHABILITATION SERVICES

Cardiac rehabilitation is a program for those with recent cardiac events. The program educates the person and his/her family about and assists them in achieving a healthy lifestyle.

Non-covered Cardiac Rehabilitation Services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Maintenance Therapy. This includes Stage Three Cardiac Rehabilitation;
b) Work hardening programs.

7) CHEMOTHERAPY

NHP will cover Medically Necessary chemotherapy administered orally, intravenously, or by injection. Oral chemotherapy will not require a higher Co-Payment, Deductible or Co-Insurance than is required for injected or intravenous chemotherapy.

IMPORTANT: *Member cost sharing will apply for chemotherapy, as set out in the medical Summary of Member Responsibility Table and Prescription Benefit Summary of Member Responsibility Table.*

8) CHIROPRACTIC CARE

NHP will cover Medically Necessary chiropractic services furnished by a Practitioner in NHP's network.

Non-covered chiropractic care
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Maintenance Therapy or Custodial Care.

8) CHIROPRACTIC CARE (continued)

b) Massage Therapy.
c) Acupuncture, acupressure and similar services. Acupuncture is a Covered Service for the treatment of nausea associated with chemotherapy, post-operative nausea, chronic headaches, chronic neck pain, chronic low back pain, and osteoarthritis of the knee.
d) Any type of holistic or homeopathic treatment.
e) Services and supplies that are not Medically Necessary.
f) Over the counter prescriptions.
g) Vitamins.
h) Self help, educational or vocational training treatment, services or supplies.

9) CLINICAL TRIAL – ROUTINE PATIENT CARE

Routine Patient Care provided to a patient during the course of treatment in a cancer clinical trial that are consistent with the usual and customary standard of care are covered by NHP as required by and limited to State of Wisconsin Statute 632.87 (6). Coverage of routine patient care during the course of treatment in a cancer clinical trial is limited to cancer clinical trials meeting all the following criteria:

a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes
b) The treatment provided as a part of the trial is given with the intention of improving the trial participant's health outcomes.
c) The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathology.
d) The trial does one of the following:

- Tests how to administer a health care service, item, or drug for the treatment of cancer.
- Tests responses 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.
- Studies new uses of health care services, items, or drugs for the treatment of cancer.

e) The trial is approved by one of the following:

- A National Institute of heath, or one of its cooperative groups or centers, under the federal department of health and human services.
- The FDA
- The Federal Department of Defense
- The Federal Department of Veteran Affairs

10) COLORECTAL CANCER SCREENING

NHP will cover colorectal cancer screening for a Member who is fifty (50) years of age or older, or who is under fifty (50) years of age and at high risk for colorectal cancer.

***IMPORTANT**: Coverage for evidence-based, Medically Necessary preventive colorectal cancer screening tests and procedures is based upon the colorectal cancer screening guidelines issued by the U.S. Preventive Services Task Force, National Cancer Institute, and American Cancer Society. The colorectal cancer screening guideline issued by the U.S. Preventive Services Task Force will be used as the primary guideline in the event of a conflict between these guidelines.*

11) DENTAL CARE FOR ACCIDENTS

NHP will cover dental care for services related to the repair or replacement of sound and natural teeth. NHP will pay *only* for teeth damaged as the result of a covered Bodily Injury that occurs while You are a NHP Member. NHP only covers services provided during the eighteen (18) month period following the date of injury.

***IMPORTANT:** Your dentist may furnish the initial evaluation related to an Accidental injury.*

NHP defines a tooth as sound and natural if, prior to the Accidental injury, ALL of the following criteria are met:

a) There is no evidence of periodontal (gum) disease;
b) The tooth is fully restored and decay free;
c) The tooth is fully functional.

Non-covered dental care for Accidents
NHP does not cover the following services, even if related to an Accident. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS, of this Certificate for a listing of "Exclusions and Limitations."

a) Services rendered more than eighteen (18) months after the date of the injury;
b) Orthodontia treatment;
c) Orthognathic surgery;
d) Osteotomy;
e) Dentures;
f) Restoration of cracked or broken teeth caused by biting or chewing;
g) Teeth whitening or bleaching.

***IMPORTANT:** NHP will not cover any dental service or treatment that cannot be completed within the eighteen (18)-month period following the date of the Accident. NHP will not extend the eighteen (18)-month limitation.*

12) DENTAL CARE IN AN AMBULATORY CARE CENTER

NHP will cover Hospital or ambulatory surgery center services, including anesthetics, for dental care furnished in the facility, if any of the following applies:

a) The Member is a child under the age of five (5).
b) The Member has a chronic disability as defined by applicable state law.
c) The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

IMPORTANT: *NHP does not cover Dentist or Oral Surgeon charges for care provided under this section.*

13) DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES

NHP will cover certain Medically Necessary DME and disposable medical supplies. NHP will only cover these when ordered by a Practitioner and purchased or rented from a Provider in NHP's network. NHP will cover DME rental up to the purchase price only.

NHP will only cover DME that meets all of the following criteria:

a) Able to withstand repeated use;
b) Ordered by a Practitioner for outpatient use primarily in a home setting;
c) Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
d) Generally not useful to the Member in the absence of a Bodily Injury or Illness;
e) Appropriate for home use;
f) Appropriate for treatment of Your Bodily Injury or Illness
g) Provided in the most cost effective manner required by Your condition, including, at Our discretion, rental or purchase.

Covered DME and disposable medical supplies
NHP will cover DME in accord with the requirements set out in this Certificate. NHP's coverage includes, but is not limited to, the following types of DME when considered Medically Necessary:

a) Prosthetics, including, but not limited to:
    - Artificial limbs;
    - External breast prosthesis;
    - Prosthetic eyes
b) Crutches and wheelchairs;
c) Apnea monitors;
d) Home uterine monitors;
e) Oxygen, oxygen related supplies and equipment;
f) Bone growth stimulator;
g) Orthotic devices, including but not limited to:

13) DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES (continued)

- Back braces;
- Custom made ankle and foot orthosis;
- Thoracic lumbar orthosis.

h) Lift mechanism only for chair lift.
i) Electronic breast pumps – basic model only
j) Standard hospital-type bed
k) Delivery pumps for tube feedings (including tubing and connectors)
l) Mechanical equipment necessary for the treatment of chronic or acute respiratory failure
m) Insulin pumps and all related necessary supplies as described under the Equipment and Supplies for Diabetes section
n) External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable "Hearing Aids & Cochlear Implants" section of this Certificate, as required by Wisconsin insurance law
o) Mastectomy bras
p) Lymphedema stockings

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to an Illness or Accident Injury. Benefits are limited as stated in the Summary of Member Responsibility Table/Summary of Benefits and Coverage.

Benefits under this section do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator, or monitor that is fully implanted into the body.

Benefits are available for repairs and replacement, except that:

a) Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
b) Benefits are not available to replace lost or stolen items.

NHP will cover DME repairs and replacement based on the average life of the product, as determined by NHP.

Non-covered DME and disposable medical supplies:
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Any item or supply available over the counter.
b) DME provided mainly for the recreation, comfort, convenience, athletic performance, or athletic participation of the Member or his/her family.
c) DME provided to adapt the home environment and items associated with such adaptations or used exclusively in the home. For example, ramps, grab bars, chair lifts, except as noted above and stair lifts.

13) DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES (continued)

d) Services and supplies that are not Medically Necessary for diagnosis and treatment of a covered Bodily Injury or Illness.
e) DME the Member uses in the absence of a Bodily Injury or Illness.
f) Items intended for the Member's comfort, personal hygiene or convenience.
g) Medical supplies or DME used for habilitative needs or services.
h) DME with features that provide more functions than are Medically Necessary for the Member. NHP will cover the standard DME model, as determined by NHP.
i) Motor vehicles or vehicle adaptations, including, but not limited to, lifts for wheelchairs and scooters.
j) Cords for hearing aids.
k) Orthopedic shoes or shoe inserts, except when custom made and Medically Necessary.
l) Wigs, toupees and any hair replacement therapies or surgery.
m) Batteries, except for diabetic equipment and covered wheelchairs.
n) Self-help devices that are not primarily medical in nature.

IMPORTANT: *To verify whether NHP will cover a specific DME item or disposable medical supply, please contact Customer Service at 1-800-826-0940.*

IMPORTANT: *Member cost sharing will apply for DME, as set out in the Summary of Member Responsibility Table/ Summary of Benefits and Coverage.*

14) EMERGENCY HEALTH SERVICES

NHP will cover Emergency Health Services with Participating and Non-Participating Providers and Practitioners if rendered in an emergency room or Hospital based Urgent Care Facility.

IMPORTANT: *NHP will not pay for care furnished outside its Service Area for the Member's convenience. This includes, for example, non-Emergency, non-Urgent Care for Member's who live outside the Service Area.*

IMPORTANT: *See paragraph thirty-five (35) for benefits NHP covers as Urgent Care Services.*

Non-covered Emergency care
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate, "Exclusions and Limitations" for a complete listing.

a) Services furnished by a Non-Participating Provider or Non-Participating Practitioners for reasonably foreseeable or predictable care the Member could have received from a Participating Provider;

b) Ambulatory non-emergent, non-urgent follow-up care furnished by a Non-Participating Provider or Non-Participating Practitioners after an Emergency;

14) EMERGENCY HEALTH SERVICES (continued)

c) Acute hospital (inpatient or observation) follow-up care furnished by a Non-Participating Provider or Non-Participating Practitioners after an Emergency;

d) Non-Emergency, non-Urgent care, except as this Certificate specifically allows.

15) EQUIPMENT AND SUPPLIES FOR DIABETES

NHP covers Medically Necessary diabetic equipment and supplies furnished by Practitioners, Providers or pharmacies in NHP's network.

NHP covers equipment, such as glucometers. NHP covers the installation and use of insulin infusion pumps. NHP also covers batteries to operate such equipment. Supplies NHP covers include insulin, syringes, test strips, alcohol and lancets.

IMPORTANT: *Cost sharing will apply, as outlined in the Summary of Member Responsibility Table/Summary of Benefits and Coverage.*

IMPORTANT: *Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Members with diabetes.*

16) GYNECOLOGICAL CARE

NHP will cover gynecological services, including annual exams.

Non-covered gynecological care
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Abortions; the directly intended termination of a pregnancy and all related charges and complications;
b) Sterilization;
c) Infertility services, supplies or prescriptions;
d) Reversals of sterilization.

17) HEALTH EDUCATION PROGRAMS

NHP will cover the following health education programs furnished and directed by a Participating Provider and/or Practitioner.

a) Diabetic Education.

Non-covered health education services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Hypnosis;
b) Health club memberships;
c) Weight loss programs;

17) HEALTH EDUCATION PROGRAMS (continued)

d) Vitamins or food supplements;
e) Purchase of exercise equipment for the home.

18) HEARING AIDS & COCHLEAR IMPLANTS

NHP offers coverage for the cost of diagnoses, procedures, surgery, and therapy related to Cochlear Implants or Hearing Aids for a covered Member who is under 18 years of age and certified as deaf or hearing impaired by a Practitioner or by an audiologist, and who meets the below criteria during the time they are covered under this Policy.

Hearing Aids: Benefits are provided for the hearing aid and for charges for associated fitting and testing. NHP covers the cost of basic hearing aids limited to one hearing device per ear, including repair or replacement, once every three years. NHP covers the cost of one bone anchored hearing aid per member who meets the following requirements:

a) For Members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

b) For Members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

19) HOME HEALTH CARE SERVICES

NHP covers Home Health Care services only when each of the following applies:

a) A formal home care program furnishes the services.
b) The services provided are skilled nursing or rehabilitation services in Your home.
c) A Participating Practitioner supervises and reviews the care every two (2) months. The Practitioner may determine that a longer period between reviews is sufficient.
d) Hospitalization or confinement in a Skilled Nursing Facility if Home Health Care services were not provided.
e) The services are Medically Necessary.

NHP will cover fifty (50) visits in any twelve (12) month period. Each consecutive four (4) hour period that a home health aide provides services is one (1) visit. NHP only covers services provided in its Service Area. A Practitioner in NHP's network must order the services.

Non-covered home health care services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Visits in excess of fifty (50) in any twelve (12) month period;
b) Private Duty Nursing;
c) Services provided by a Family Member;
d) Take home drugs dispensed prior to Your release from confinement;
e) Services and supplies that are not Covered Services or that are not related to the Home Health Care services being provided.

19) HOME HEALTH CARE SERVICES (continued)

f) Maintenance services

IMPORTANT: *Physical, Occupational and Speech Therapy rendered in the home will apply to the Home Health Care visit maximum.*

IMPORTANT: *Nursing or rehabilitation services may be Palliative Care as long as the services are not Custodial.*

20) HOSPICE CARE

NHP covers Hospice care if:

a) The Member's Practitioner certifies that the Member's life expectancy is six months or less;
b) The care is Palliative Care; and
c) The Hospice care is received from a licensed Hospice agency.
d) Services may be furnished in a Hospice facility housed in a Hospital, a separate Hospice unit or in Your home. A Hospice facility housed in a Hospital must be in a separate and distinct area.
e) Hospice care services are provided according to a written care delivery plan developed by a Hospice care provider and by the recipient of the Hospice Care services.

IMPORTANT: *Hospice care services include but are not limited to: Practitioner services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies & Durable Medical Equipment; occupational, physical, or speech therapies; volunteer services; Home Health Care services; and bereavement services.*

Respite care may be provided only on an occasional basis (once per 60 Days) and may not be reimbursed for more than five (5) consecutive Days at a time.

21) HOSPITAL - INPATIENT SERVICES

NHP covers inpatient services furnished in a licensed Hospital, Skilled Nursing Facility or rehabilitation facility. The services must be Medically Necessary. NHP will cover the cost of a Semi-Private room. NHP will cover care in a private room or intensive or coronary care facility only if Medically Necessary.

A Member needing inpatient care or the Member's treating Provider must give notice to NHP within forty-eight (48) hours of admission. Notice may be given on the next business day after admission if the forty-eight (48) hours ends on a weekend or holiday. NHP must receive all details concerning the Member's care and proposed plan of care.

IMPORTANT: *NHP covers prescription drugs that Providers furnish during inpatient stays. NHP does not cover other prescription drugs unless You have Prescription Drug Rider coverage. If You have Prescription Drug Rider coverage, NHP covers prescription drugs as outlined in Your Prescription Drug Rider.*

21) HOSPITAL - INPATIENT SERVICES (continued)

Non-covered inpatient services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Private room charges unless Medically Necessary;
b) Take home drugs dispensed prior to Your release from confinement;
c) Services that are not Covered Services or that are not provided in accord with the terms and conditions of this *Certificate*.

22) KIDNEY DISEASE SERVICES

NHP will cover chronic renal failure. NHP will cover only Medically Necessary services furnished by a Participating Provider. Coverage includes:

a) Dialysis;
b) Transplantation (see Section 26) Organ and Tissue Transplant Services); and
c) Services related to donation when recipient is a NHP Member.

Non-covered kidney disease services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Kidney disease services for which the Member is eligible for reimbursement by Medicare;
b) Any artificial organ transplants;
c) Any animal to human organ transplants.

23) MAMMOGRAPHY SERVICES

NHP will cover low dose screening mammography exams. A NHP network Practitioner must furnish the services at a Participating facility.

24) MATERNITY CARE

NHP covers Medically Necessary routine maternity care. Routine services covered include:

a) Monthly visits up to twenty-eight (28) weeks gestation;
b) Biweekly visits from twenty-nine (29) to thirty-six (36) weeks gestation;
c) Weekly visits after thirty-six (36) weeks until delivery;
d) Delivery in a Hospital;
e) Post-Partum care. Such care includes Hospital and office visits.

Non-covered maternity care
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Diagnostic tests solely to determine the gender of a fetus. NHP will cover tests that are Medically Necessary to determine the existence of a sex linked genetic disorder;

24) MATERNITY CARE (continued)

b) Abortions; the directly intended termination of a pregnancy and all related charges and complications;
c) Births at stand-alone birth centers, home births and related services.

IMPORTANT: *Member cost sharing may apply to office visits for services provided in a complicated pregnancy. See Your Summary of Member Responsibility Table/Summary of Benefits and Coverage.*

IMPORTANT: *The initial office visit is generally considered to be diagnostic and not maternity care. Therefore, it may be billed as a diagnostic office visit, separate from other maternity care, and the applicable plan provisions applied such as Co-Payments, Deductible, and/or Co-Insurance.*

IMPORTANT: *Please notify NHP's Care Management Department of Your pregnancy during Your first trimester.*

IMPORTANT: *For continuity of their care, Members new to the plan in their third trimester of pregnancy (the third trimester starts at 26 weeks gestation) may continue to receive obstetric care from their Non-Participating Practitioner and/or Non-Participating Provider provided the care is Prior Authorized. Members in their first or second trimester (starting at conception through 25 completed weeks gestation) upon initial enrollment must transition to a Participating Practitioner and/or Provider. Authorization of Non-Participating obstetrical services does not extend to care for the infant.*

25) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

NHP will cover services for Mental Health and Substance Abuse Disorders subject to the Benefits limits described in the Summary of Member Responsibility Table/Summary of Benefits and Coverage. Such services must be Medically Necessary services for the prevention, diagnosis, or treatment of Mental Health and Substance Abuse Disorders. NHP will cover only services that are appropriate, as set forth in this Certificate.

Outpatient Benefits
NHP covers office, clinic and outpatient Hospital visits. If necessary for the Member's treatment, the family unit may obtain these outpatient benefits.

Inpatient Benefits
NHP will cover Medically Necessary inpatient Mental Health Disorder and Substance Abuse Disorder services furnished in appropriately licensed facility such as a Hospital, Skilled Nursing Facility, rehabilitation facility, or other licensed facility. NHP will cover the cost of a Semi-Private Room. NHP will cover care in a private room or intensive care facility when Medically Necessary. A Member needing inpatient care must give Us notice within 48 hours of admission or on the next business day after admission.

IMPORTANT: *NHP covers prescription drugs that Providers furnish during Inpatient stays. We do not cover other prescription drugs unless You have Prescription Drug Rider coverage.*

25) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (continued)

If you have Prescription Drug Rider coverage, We cover prescription drugs as outlined in the Rider.

IMPORTANT: *You are responsible for obtaining Authorization when receiving services from a Non-Participating Provider.*

NHP will cover court ordered services for Mental Health Disorders and Substance Abuse Disorders to the extent services are furnished in full compliance with this Certificate, unless ordered pursuant to an Emergency detention or on an Emergency basis. If a Non-Participating Provider or a Non-Participating Practitioner furnishes these Emergency court ordered services, the Member must notify NHP within forty-eight (48) hours or the next business day. NHP will not cover the services without notice.

IMPORTANT: *NHP covers services for Emergency Mental Health Disorders and Substance Abuse Disorders regardless of where the crisis occurs. NHP covers services for persons experiencing a mental health crisis or in a situation that, if left untreated, would likely become a crisis without proper support.*

Transitional Care
NHP will cover Transitional Care services for Mental Health Disorders and Substance Abuse Disorders including treatment in a Residential Treatment Facility and Intensive Outpatient Therapy. Services must be Medically Necessary. We will cover Transitional Care in a Residential Facility as an inpatient benefit (as described above). We will cover Transitional Care furnished as Intensive Outpatient Therapy as an outpatient benefit (as described above).

Outpatient Benefits for College Students
NHP will cover the following services for Mental Health Disorders or Substance Abuse Disorders furnished to You or Your covered Dependent without prior Authorization when (a) You or the Covered Dependent is attending school outside NHP's Service Area; (b) the services are furnished by a Non-Participating Practitioner or, Non-Participating Provider; and(c) the services are furnished reasonably close to the school:

- A clinical assessment of the problem.
- Up to six outpatient visits.

The provider should contact NHP to request Authorization for further treatment, if necessary.

Once You or Your covered Dependent is no longer enrolled in school or treatment prevents You or the Covered Dependent from attending school, prior Authorization is required for all services rendered by Non-Participating Practitioner or Non-Participating Provider. For the purposes of this section, "school" means a vocational, technical and adult education school, or any institution of higher education.

26) ORGAN AND TISSUE TRANSPLANT SERVICES

NHP will cover organ and tissue transplant services. A Member must meet the following criteria:

a) Member's Practitioner and NHP must approve, in writing, the covered organ or DNA tissue transplant and related services.
b) The Member's condition must meet the applied medical necessity criteria in addition to being approved by NHP's Participating Transplant Program Provider and NHP.
c) The specific type of transplant must be effective therapy for the Member's condition. Expert medical professionals at a NHP approved transplant center will make this determination for NHP.
d) The potential benefit of the transplant must outweigh the potential risk.
e) The specific type of transplant must provide more benefit than other therapies, given the Member's medical condition.
f) The specific type of transplant must improve transplant Member's quality of life and health or functional status. To determine this, NHP will rely only on scientifically designed and controlled research studies. NHP will rely only on such studies published in peer reviewed medical publications that are accepted as appropriate by the transplant or oncology academic communities.
g) The Member must not have a terminal disease that the transplant would not correct or cure.

Services covered
NHP will approve transplants that meet the following criteria:

a) Have available for transplant appropriate donor organs, bone marrow or stem cells.
b) An approved NHP Participating Transplant Program Provider must furnish the care.
c) Are not Unproven, Experimental, Investigational, or for Research Purposes; and
d) Care must be provided in full compliance with the Certificate.
e) Health services for a Member's organ donor, including, but not limited to compatibility testing for live donors. These costs are subject to the Coordination of Benefits provisions specified in Article V of this Certificate.

NHP covers the following organ and tissue transplant services, subject to the restrictions described above.

a) Medical, surgical, and Hospital services and costs related to obtaining organs. This includes services required to perform the following human organ or tissue transplants.

    - Heart;
    - Liver;
    - Liver/Intestine
    - Pancreas;
    - Bone Marrow (Autologous self to self or Allogenic other to self);
    - Kidney;
    - Heart/Lung;

26) ORGAN AND TISSUE TRANSPLANT SERVICES (continued)

- Single Lung;
- Bilateral Sequential Lung;
- Corneal ;
- Kidney/Pancreas;
- Intestinal.
- Re-transplantation for the treatment of bone marrow or kidney disease.

b) Immunosuppressive or anti-rejection medications. These drugs must be for an approved transplant. Member cost sharing may apply, as described in the Summary of Member Responsibility Table/Summary of Benefits and Coverage.

c) Health services for a Member's organ donor, including, but not limited to compatibility testing for live donors. These costs are subject to the Coordination of Benefits provisions specified in Article IV of this Certificate.

Non-covered organ and tissue transplant services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Any organ or tissue re-transplantation not otherwise covered by the Certificate. This does not apply to kidney re-transplantation for the treatment of kidney disease or bone marrow re-transplantation.
b) Services not related to the diagnosis or treatment of an Illness resulting directly from such transplants.
c) Drugs determined to be Unproven, Experimental, Investigational or for Research Purposes. This includes drugs not approved by the FDA for marketing.
d) Services for which Medicare will pay.
e) Transplants and recipients that do not meet the indications and criteria of NHP's Participating Transplant Program Providers.
f) Transplants for Members with significant multi-system infections.
g) Transplants for Members with malignancy. This applies if malignancy is in either the primary organ to be transplanted, is metastatic or in another primary site. This does not apply to bone marrow malignancy.
h) Transplants for Members with severe acute hemodynamic compromise at the time of transplant.
i) Transplants for Members who are actively abusing alcohol or drugs.
j) Transplants for Members with history of behavior pattern or psychiatric Illness likely to significantly interfere with medical regimen compliance. NHP's Participating Transplant Program Provider will make this determination with NHP and the Member's Practitioner.
k) Animal to human transplants.

All covered organ and tissue transplant services are subject to the terms of the Summary of Member Responsibility Table/Summary of Benefits and Coverage, including:

26) ORGAN AND TISSUE TRANSPLANT SERVICES (continued)

a) Member cost sharing.
b) Organ and Tissue Transplant Services limits, if any.
c) Member cost sharing for immunosuppressive or anti-rejection medication.

27) OUTPATIENT HOSPITAL SERVICES

NHP will cover Medically Necessary outpatient Hospital services. The services must be furnished by a licensed Hospital that is in NHP's network. NHP will pay only for services that are Medically Necessary. A Participating Practitioner must direct the services.

IMPORTANT: *Member must obtain Prior Authorization for out-of-plan Hospital outpatient services.*

28) PREVENTIVE SERVICES

NHP will cover routine evaluation and management of Member's health. This includes routine immunizations. A Participating Practitioner in NHP's network must furnish these services.

NHP pays for:

a) Periodic physical exams. The frequency and type of exams are based on the Member's age, sex and medical history.
b) Preventive child care exams for school, camp and sports.
c) Preventive child care exams from birth for a child enrolled as a Member.

Non-covered preventive services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Third party requests for supplies and services;
b) Immunizations, exams or prescriptions requested by a third party or by a Member solely for travel, recreational, higher education or employment purposes.

29) PROVIDER AND PRACTITIONER SERVICES

NHP will cover Provider and Practitioner services. NHP will pay only for services that are Medically Necessary. Services must be for the prevention, diagnosis or treatment of a Bodily Injury or Illness. For example, NHP will cover the following types of services:

a) Physical exams, office visits and procedures, Hospital and home visits;
b) Administration of drugs, immunizations, and allergy injections;
c) Surgery;
d) Hearing acuity testing;
e) Lead poisoning screenings;
f) Skilled Nursing Facility and Residential visits;
g) Anesthesiology services;
h) Laboratory, radiology and other diagnostic services and testing;

29) PROVIDER AND PRACTITIONER SERVICES (continued)

i) Chemo and radiation therapy;
j) Routine foot care for metabolic or peripheral disease or if skin or tissue is infected;
k) Palliative Care services.
l) Acupuncture is a Covered Service for the treatment of nausea associated with chemotherapy, post-operative nausea, chronic headaches, chronic neck pain, chronic low back pain, and osteoarthritis of the knee.
m) Inpatient rehabilitation facility or Alternate Facility;
n) Scopic procedures include: arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy;
o) Tests to determine the existence of a sex linked genetic disorder;
p) Tobacco counseling: NHP will cover the cost of one annual screening and two tobacco-quitting attempts per year. Each attempt includes coverage for up to four tobacco-counseling sessions of at least 10 minutes each (including telephone, group and individual counseling) for a maximum of eight tobacco-counseling sessions per year.
q) Covered Services include medical education services that are provided in a Practitioner's office by appropriately licensed or registered healthcare professionals when both of the following are true:

   a. Education is required for a disease in which patient self-management is an important component of treatment.

   b. There exists a knowledge deficit regarding the disease which requires the intervention of a training health professional.

r) Virtual visits for covered Telemedicine services that include the diagnosis and treatment of specified medical conditions through electronic means. Benefits are available only when services are delivered through NHP's defined virtual care contracted provider network. Any prescriptions the health practitioner deems appropriate will be covered under the pharmacy benefit of the medical plan.

IMPORTANT: *All services are subject to any terms, conditions, limitations, restrictions and exclusions in this Certificate.*

IMPORTANT: *NHP covers specified smoking cessation pharmacy products.*

IMPORTANT: *NHP will cover at least all of the following immunizations for children under the age of 7, with no cost sharing requirement:*

Diphtheria;	*Polio;*	*Rubella;*	*Rotavirus;*
Measles;	*Varicella;*	*Hepatitis B;*	*Pertussis;*
Mumps;	*Tetanus;*	*Hemophilus Influenza B Injection;*	

Non-covered Practitioner services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

29) PROVIDER AND PRACTITIONER SERVICES (continued)

a) Services that are not Medically Necessary. NHP will not pay for services related to complications caused by services that were not Medically Necessary. NHP will base its
b) decision of the Medical Necessity of a service on generally accepted standards of the U.S. medical community.
c) Services that are, in NHP's view, Unproven, Experimental, Investigational or for Research Purposes.
d) Service levels that are not appropriate to the procedure or service, based on national standards.
e) Human Chorionic Gonadotropin injections.
f) Acupuncture, acupressure and similar services, except as listed above.
g) Behavioral training.
h) Sex change treatments or procedures.
i) Prayer or spiritual healing.
j) Services for hair analysis, hair loss and all forms of alopecia. This applies to any such treatment, procedure, service, device, supply or drug. NHP does not cover hair replacements, wigs, toupees or hair replacement therapies.
k) Massage therapy.
l) Hypnosis therapy.
m) Any type of holistic or homeopathic treatment.
n) Maintenance Therapy.
o) Custodial Care.
p) Reconstructive, plastic or Cosmetic Surgery. NHP will not pay for any treatment undertaken solely to improve the Member's appearance. NHP will cover Medically Necessary services that correct a functional defect caused by a Bodily Injury or Illness. Psychological impact is not a functional defect caused by a Bodily Injury or Illness.
q) Services and supplies that are not Covered Services.
r) Therapy or treatment for Developmental or Learning Disability or Delays.
s) Sublingual (under the tongue) allergy testing or treatment drops.
t) Routine foot care (unless for a diabetic condition).
u) Sexual or erectile dysfunction or impotence.
v) Lyme disease vaccine.
w) Treatment of obesity, except for diet counseling for the treatment of obesity.
x) Treatment and services for Rett's Disorder, and sensory integration or defensiveness.

30) RECONSTRUCTIVE SURGERY

NHP will cover Reconstructive Surgery and related Covered Services as necessary:

a) To treat a Bodily Injury or Illness or a congenital disease or anomaly that causes a functional bodily impairment.
b) To improve or repair an abnormal condition of a body part that is the result of, or incidental to, a surgery done on that part. This applies only if the initial surgery was for the diagnosis or treatment of a Covered Service.

30) RECONSTRUCTIVE SURGERY (continued)

c) For breast reconstruction due to a mastectomy. *For a description of Your Benefits please refer to number5) Breast Reconstruction.*

Non-covered reconstructive surgery services
NHP does not cover Cosmetic Surgery and related services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

31) REHABILITATION

NHP will cover inpatient or outpatient Rehabilitation Services. Such services may include speech, physical or occupational therapies. NHP will only pay for such services if they:

a) Are Medically Necessary and appropriate;
b) Significantly restore function lost due to a covered Illness or Bodily Injury;
c) Provide either:

- Training in the use of covered prosthetic or orthopedic devices; or
- The ability to care for oneself while restoring the function lost under b) above. This includes feeding, toilet activities and ambulation.

IMPORTANT: *An inpatient rehabilitation facility must furnish any inpatient services.*

Non-covered rehabilitation services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Services that are primarily educational in nature, other than as specifically described;
b) Services for the treatment of Learning or Developmental Delay disorders;
c) Maintenance Therapy;
d) Habilitative Services;
e) Custodial Care and maintenance care;
f) Therapies that are educational;
g) Behavioral training;
h) Treatment and services for sensory integration and sensory defensiveness.

32) SKILLED NURSING FACILITY (SNF)

NHP will cover daily (or swing bed) room, board, and general nursing services, if:

a) A SNF furnishes the care;
b) The patient entered the SNF within twenty-four (24) hours of discharge from a covered Hospital confinement;

NHP will not pay for more than sixty (60) Days per Confinement Period. A Confinement Period begins on the first day You enter a SNF and ends upon discharge to a lower level of care.

32) SKILLED NURSING FACILITY (SNF) (continued)

Non-covered SNF services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Custodial or maintenance care;
b) Services that can be provided at an ambulatory or home care level;
c) SNF or swing bed days in excess of sixty (60) Days per Confinement Period; and
d) Take home drugs dispensed prior to Your release from confinement.

33) TREATMENT FOR TEMPOROMANDIBULAR ("TMD") DISORDERS

NHP will cover services for TMD if ALL of the following apply:

a) The condition is caused by congenital, developmental or acquired deformity, disease or injury.
b) The services are reasonable and appropriate for the diagnosis or treatment of TMD. NHP will use the accepted standards of the profession of the treating Practitioner to decide if services are reasonable and appropriate.
c) The service controls or eliminates:

    - Infection;
    - Pain;
    - Disease; or
    - Dysfunction.

d) The treatment is Medically Necessary.

IMPORTANT: *NHP limits coverage for diagnostic procedures and non-surgical treatment for TMD to $1,250.00 per year. Non-surgical services include prescribed intraoral splint therapy devices.*

Non-covered TMD services
NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Periodontic care;
b) General dental care;
c) Any procedure, device or treatment for plastic or Cosmetic Surgery or to improve the Member's appearance.

34) URGENT CARE SERVICES

In the Service Area:

NHP will cover Urgent Care furnished by a Participating Provider or Urgent Care center.

Outside the Service Area:

34) URGENT CARE SERVICES (continued)

NHP with cover Urgent Care only when furnished by an Emergency room or Hospital-based Urgent Care Facility.

***IMPORTANT**: NHP will not pay for out of area services for the Member's convenience.*

***IMPORTANT**: A Participating Practitioner must furnish care following an Urgent Care visit.*

***IMPORTANT**: See Section 14 for benefits NHP covers as Emergency care.*

***IMPORTANT**: NHP considers a College Student's home to be his/her permanent place of residence.*

Non-covered Urgent Care services

NHP does not cover Urgent Care Services or treatment furnished by a Non-Participating Provider or a Non-Participating Practitioner that is in NHP's Service Area. NHP does not cover Urgent Care services or treatment furnished outside NHP's Service Area, except services furnished by an Emergency room or Hospital-based Urgent Care Facility or unless notified within 48 hours or the next business day of receiving the urgent service. Please refer to *ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."*

35) VISION CARE SERVICES

NHP will cover routine eye exams. The exam may screen for eye disorders and assess the need for prescription corrective or contact lenses. NHP will only pay for services a Participating Practitioner furnishes.

NHP will cover one (1) routine eye exam/eye refraction for each Member in a *twelve (12) month period.*

***IMPORTANT:** You may have to pay some cost sharing for routine eye exams. Member cost sharing is described in the Summary of Member Responsibility Table/Summary of Benefits and Coverage.*

***IMPORTANT:** Once per lifetime, NHP will cover one (1) basic pair of eyeglasses after cataract surgery. The amount NHP will cover for eyeglasses will not exceed $160.00*

Non-covered vision care services

NHP does not cover the following services. Please refer to ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS of this Certificate for a listing of "Exclusions and Limitations."

a) Glasses or contact lenses or their measurement, fitting and adjustment;
b) Vision therapy including eye exercises;
c) Surgery to correct vision, including but not limited to:

35) VISION CARE SERVICES (continued)

- Radial Keratotomy (RK);
- Astigmatic Keratotomy (AK);
- Automated Lamellar Keratoplasty (ALK);
- Excimer Laser;
- Photorefractive Keratotomy (PRK);
- Phototherapeutic Keratotomy (PTK);
- Laser assisted Insitu Keratomileusis (LASIK);
- Corneal modulation;
- Refraction Keratoplasty;
- Orthoptic pleoptic training aids

ARTICLE III ~ OBTAINING HEALTH SERVICES

Article III outlines NHP's requirements for Obtaining Health Services.

1) PRIMARY CARE PRACTITIONER (PCP)

As a managed care plan, NHP strongly recommends that upon enrollment, each Member selects a Primary Care Practitioner (PCP).

A PCP directs and coordinates a Member's health care. The PCP provides routine care, coordinates needed specialty care and assists Member in obtaining Authorizations from NHP.

As a managed care plan, NHP recommends You utilize a Participating Practitioner to manage Your health care services.

Selecting a primary care physician (PCP) is very important. If you have not selected a PCP, Network Health will assign you one. If you'd like to designate a PCP, please share this information with Network Health customer service by calling the number on your ID card. If you haven't or don't wish to designate a PCP, Network Health will rely on claims data to assign you a PCP. Our system automatically assigns PCPs to members based on primary care doctors you've seen the most who are part of your plan and accepting new patients. For those who haven't seen a PCP in two years, Network Health will work with our provider partners to assign you a PCP who is in your area and accepting new patients. Whether your PCP is selected or assigned, you'll receive the same high quality care you've come to expect, and we will communicate with your PCP to help coordinate your care.

2) PRIOR AUTHORIZATION AND PRE-ADMISSION REVIEW

NHP reviews certain services and treatment plans to ensure they are Medically Necessary and appropriate. A Member or the Member's treating Practitioner must obtain from NHP Prior Authorization or pre-admission review to receive coverage for these services.

IMPORTANT: *Examples of health services that require prior NHP review are:*

- *Entering a Hospital as a scheduled (non-Emergent) inpatient, and*
- *Obtaining non-Emergent, non-Urgent services from a Non-Participating Practitioner or Provider.*

You may contact Your Participating Practitioner or NHP's Customer Service Department for information on other health care services that require Prior Authorization. Your Practitioner may make a request for Prior Authorization on Your behalf.

IMPORTANT*: It is Your responsibility to obtain NHP's Prior Authorization, when required before receiving health care services from Non-Participating Practitioners or Providers.*

IMPORTANT: *For non-urgent, non-emergent services with Non-Participating Practitioners or Providers, You must notify NHP prior to receiving the service or You may be held financially responsible for the costs of those services.*

2) PRIOR AUTHORIZATION AND PRE-ADMISSION REVIEW (continued)

IMPORTANT: *NHP's Prior Authorization does not mean that NHP will cover a health service or item. All other provisions in this Certificate, including the Exclusions and Limitations and any applicable Rider(s), will also affect whether NHP covers a health service or item.*

IMPORTANT: *NHP cannot review or Authorize coverage outside of the current Contract Year.*

Your Practitioner or an authorized Provider should contact NHP's Utilization Management Department to obtain Prior Authorization. Your Practitioner or authorized Provider should make the request at least fourteen (14) business Days prior to rendering the service. NHP's Utilization Management Department will review the Practitioner's request at least two (2) Days prior to the requested service. NHP will determine whether the service is Medically Necessary and appropriate. NHP will furnish written or verbal notice of its decision, as NHP deems appropriate, to one or more of the following:

a) The Member;
b) The Member's Practitioner;
c) The treating Practitioner and/or Provider.

3) NOTICE OF EMERGENCY ADMISSIONS

You should notify NHP within forty-eight (48) hours (or the next business day) of any inpatient admissions following an Emergency Department visit, if possible. NHP's Utilization Management Department will review the admission within two (2) business days of notice. NHP will notify You and Your treating Practitioner and/or Provider of approval Authorization for or denial Authorization of any continued stay.

IMPORTANT: *If You are admitted to a Non-Participating hospital facility following an urgent care or Emergency Department visit, You must notify NHP within 2 business days of discharge from the facility or You may be held financially responsible for the cost of the services.*

4) DISCHARGE PLANNING

NHP is available to work with Members to plan needed medical care and a smooth transition when leaving a Hospital or other health care facility. NHP staff may contact You to help with Your discharge plan.

5) SECOND OPINION

NHP Member's may obtain a second opinion from a Participating Practitioner to make clear, review or confirm a diagnosis or treatment plan. You or Your covered Dependent Practitioner may request a second opinion. The Practitioner of a second opinion may not furnish care or perform any procedure at the time of the evaluation.

6) CASE MANAGEMENT

NHP provides case management services for chronically, catastrophically or terminally ill or injured Members. The goal of case management is to ensure that care is well coordinated, to enhance the Members quality of life and to promote the most cost effective use of the Member's Benefits. This program:

a) Informs Members and Practitioners of the Member's Benefits;
b) Identifies appropriate treatment options;
c) Arranges and coordinates Medically Necessary, provider, and community services, including but not limited to Home Care, Palliative Care and Hospice services.

7) DENIALS OF AUTHORIZATIONS OR CONTINUED STAY REQUESTS

NHP's Utilization Management Department will apply medical review criteria to a:

a) Procedure;
b) Continued length of stay;
c) Treatment plan;
d) Health service;
e) Health item;
f) Site of care.

NHP will deny any request for Authorization for services or continued stay that does not meet its medical review criteria. NHP will provide written notice of a denial to You, Your Practitioner(s) and/or Your Provider. The written denial notice will include:

a) A statement that the requested health service does not meet NHP's criteria for Medically Necessary or appropriate care;
b) The Certificate and/or the Medical Necessity guideline provision that served as the basis for the denial;
c) An explanation of the Member Grievance Resolution Process.

ARTICLE IV ~ COORDINATION OF BENEFITS (COB)

NHP will coordinate benefit payments with other Group health care coverage that You may have, as set forth below. The purpose of this provision is to ensure that You receive the Benefits to which You are entitled without providing more Benefits than the total cost of care received.

1) ALLOWABLE EXPENSE

Allowable Expenses are services that NHP or another Group health plan covers.

2) ORDER OF DETERMINATION

The rules below determine which Group health plan is primary and which Group health plan is secondary.

a) No COB provision: If the Member's other Group health plan does not have a COB provision, that plan will be primary.
b) Non-Dependent/Dependent: A Primary Insured's plan will be primary over a plan that covers that Primary Insured as a Dependent.
c) Dependent children: The "Birthday Rule" will determine which plan is primary for a Dependent child with coverage under both parents' plans.

Birthday Rule:

The plan of the parent whose birth date occurs first in a calendar year is primary. If both parents have the same birth date, the plan that has covered the parent for a longer period of time is primary.

Dependent children with unmarried, separated or divorced parents:

The rules below determine which Group health plan is primary for a child for whom a court order awards custody to one parent.

a) The plan of the parent with custody of the child is primary.
b) If the custodial parent has no plan, the plan of the custodial parent's spouse is primary.
c) If neither the custodial parent nor his/her new spouse has a plan, the plan of the parent who does not have custody of the child, or their spouse is considered primary.

If the specific terms of a court decree state that the parents have joint custody and do not specify which parent is responsible for health care expenses, the Birthday Rule will apply.

If a court decree orders that one parent is responsible for health care expenses, the plan of that parent will be primary.

> ***IMPORTANT:*** *These rules for Dependent children of divorced or separated parents only apply after NHP has been informed of the court ordered terms.*

3) ACTIVE/INACTIVE EMPLOYEE

If a spouse is laid off or retired, a plan that covers an actively at work spouse is primary for the inactive spouse and their Dependents.

4) CONTINUATION OF COVERAGE

The plan that covers a Member as an actively at work employee or Dependent is primary over any continuation of coverage plan.

5) LONGER/SHORTER LENGTH OF COVERAGE

If none of the above rules determines the order of Benefits, the plan that has covered the person for a longer period of time will be primary.

6) EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY

NHP will apply these provisions to Allowable Expenses payable under both NHP and any other plan. To be eligible, You must incur the Allowable Expenses while You are an NHP Member and Claims must be submitted to NHP within ninety (90) Days of receipt of the primary Group health plan's explanation of Benefits. These provisions apply only when the sum of the amount NHP covers for Allowable Expenses under NHP and the amount of Allowable Expense any other plan covers, in the absence of this COB section or any similar provision in the other plan, exceed the amount of Allowable Expenses.

NHP will cover Allowable Expenses incurred by You while You are a NHP Member as follows:

a) If NHP is primary, NHP will pay Benefits without regard to any other plan;
b) If another plan is primary, NHP will reduce Benefits so that total Benefits payable by all plans will not exceed the total of Allowable Expenses.

7) COB WITH MEDICARE

COB with Medicare will conform to Federal Statutes and Regulations.

IMPORTANT: *Except as required by Federal Statutes and Regulations, NHP is secondary to Medicare.*

8) RIGHT TO NECESSARY INFORMATION

NHP may need information to determine proper payment. NHP may obtain that information from any organization or person without Your consent, but will do so only as needed to apply these COB rules. NHP may give necessary information to another organization or person in order to coordinate Benefits.

IMPORTANT: *NHP uses and discloses confidential medical and patient information only as State and Federal law allows.*

9) FACILITY OF PAYMENT

NHP may directly pay another plan that pays an amount NHP should have paid.

10) RIGHT TO RECOVERY

NHP may recover payments NHP makes that are in excess of the amount owed. The Member grants NHP a lien against any amounts that NHP pays to the Member or to a third party on the Member's behalf and NHP may recover from the Member or such third party an amount equal to the excess payment made under this Article.

ARTICLE V ~ EFFECTIVENESS OF COVERAGE

1) ELIGIBILITY

Employees and their Dependents become eligible for NHP coverage as explained below.

If You or Your Dependent(s) have been or are found to be ineligible for coverage for an identified timeframe, and Providers have been reimbursed for dates of services within that timeframe, You or the responsible party will be required to reimburse NHP for all sums paid, including attorney's fees and expenses if incurred.

2) EMPLOYEE

Employees and Dependents are eligible for NHP coverage as specified in the Employer's Group application. Employees must apply within thirty-one (31) Days of becoming eligible. If the employee does not apply during that time, the employee and Dependents may only enroll in three (3) cases:

a) During the employer's annual open enrollment period, if any;
b) As a late enrollee, as outlined below;
c) During a special enrollment period, as outlined below.

IMPORTANT: *To enroll, You must work in NHP's Service Area. See "Primary Insured in the Defined Terms section.*

IMPORTANT*: You must begin work to be eligible. NHP will not cover a new hire until s/he begins full-time work.*

3) LATE ENROLLEES

Eligible employees and Dependents who did not enroll when initially eligible for coverage and who are not eligible under the special enrollment period as specified below, are considered "late enrollees." Late enrollees may be subject to a bona fide employment-based orientation period not to exceed one month and a waiting period up to, but not to exceed 90 days.

IMPORTANT: *When an employee changes from non-eligible to eligible status, the employee must abide by the employer's applicable waiting period. (e.g. changing from part time to full time status.)*

4) SPECIAL ENROLLMENT PERIODS

Eligible employees and eligible Dependents who did not enroll when first eligible may enroll for NHP coverage during a special enrollment period. To qualify the applicant must have originally declined coverage with the employer because he/she was covered by another Group health plan. Special enrollment applies to the following:

a) Employee, spouse and newly eligible Dependents as a result of a qualifying event (i.e. marriage or newborn/adopted children). Other Dependents are not eligible as a result of this qualifying event;

4) SPECIAL ENROLLMENT PERIODS (continued)

b) Coverage Effective Date for loss of coverage or marriage will be no later than the first of the month following the qualifying event;

c) Coverage Effective Date for birth or adoption is the date of the qualifying event;

d) Enrollment must be requested within thirty-one (31) Days of the loss of other coverage or qualifying event.

5) DEPENDENT SPECIAL ENROLLMENT PERIODS

If the Dependent is not enrolled during the thirty-one (31) Day period, enrollment will be restricted to the Employer's annual open enrollment period or as indicated in the special enrollment period guidelines. If the Employer does not have an annual open enrollment period, enrollment will be limited to the special enrollment period guidelines or as a late enrollee.

A Dependent becomes eligible for coverage:

a) On the date the Primary Insured is eligible for coverage;
b) The date of marriage for a Primary Insureds spouse and stepchildren;
c) The date of birth of the Primary Insured's natural-born child;
d) The date a child is placed in the Primary Insured's home for adoption or the date that a court issues a final order granting adoption of the child to the employee, whichever occurs first;
e) The date of birth of a child born to the Primary Insured's covered Dependent child who is under the age of eighteen (18). Coverage of the Subscriber's grandchild terminates the date the grandchild's parent reaches age eighteen (18).
f) The date of a court order requiring the Primary Insured to provide health coverage for a Dependent child.

A special enrollment period lasting sixty (60) Days begins for a Member's newly born child on the date of birth. The Effective Date of coverage is the date of birth. If the Member fails to enroll the newborn within sixty (60) Days, the Member may enroll the newborn within one (1) year of birth by making all past-due payments with 5 1/2% annual interest.

A special enrollment period lasting sixty (60) Days begins for a Member's adopted child at the earlier of the adoption or placement date, with proof of guardianship papers. Coverage begins at the earlier of the adoption or placement date. The Member must pay the applicable Premium within sixty (60) Days of the child first becoming eligible.

6) ENROLLMENT CHANGES

Changes to the enrollment form must be made by completing a change form. All changes must be made within thirty-one (31) Days of the change. The change form is available through Your employer.

ARTICLE VI ~ TERMINATION OF COVERAGE

1) TERMINATION OF COVERAGE

Your coverage terminates when:

a) NHP or Your Employer terminates the Policy.
b) You cease to be an eligible Primary Insured, as specified on the Employer's Group Application.
c) You notify NHP via the enrollment/change form that You wish to cancel enrollment.
d) For spouses, the date of the divorce or otherwise stated by the Employer.
e) Death of the Employee.

IMPORTANT: *Your Dependent's coverage terminates when s/he ceases to be a Dependent.*

IMPORTANT: *For a Dependent who is eligible for coverage and a Full-Time Student on medical leave, coverage will terminate no later than one year from the date on which the Dependent is unable to attend classes as a result of the medical leave.*

2) DISENROLLMENT OF COVERAGE

NHP will terminate a Member's if the Member:

a) Fails to pay Premiums in accordance with this Policy;
b) No longer resides in the NHP Service Area;
c) Performs an act or practice that constitutes fraud (including, but not limited to allowing another person to use the Member's identification card or makes an intentional misrepresentation of material factor in connection with coverage.

NHP will terminate coverage prospectively, except in the event a Member performs an act or practice under paragraph c), in which case NHP may rescind coverage.

NHP will terminate a Member's coverage if NHP ceases to be eligible to offer such coverage under Federal or State law.

3) TERMINATION OF THE GROUP POLICY

NHP will continue to provide medical Benefits to a covered Members who is Totally Disabled due to a covered Bodily Injury or Illness that exists when the Policy terminates, until the earliest of the following:

a) The date the Member's Practitioner certifies that s/he is no longer Totally Disabled;
b) The date the maximum benefit is exhausted;
c) Twelve (12) months after termination of coverage.
d) The date similar coverage for the condition or conditions causing Total Disability is provided, other than temporary coverage under a succeeding insurer's Group policy.

IMPORTANT: *This provision applies only to Covered Services relating to the condition for which the Member was hospitalized when the Member's coverage terminated.*

ARTICLE VII ~ RECOVERY RIGHTS

Subrogation and Reimbursement

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 a third party causes or is alleged to have caused 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.
- 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:

- Your failure to cooperate with Us is considered a breach of contract. As such, We have the right to terminate Your Benefits, deny future Benefits, take legal action against You, and/or set off from any future Benefits the value of Benefits We have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with Us. If We incur attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, We have the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold which should have been returned to the Plan.
- 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.

- We may, at Our option, take necessary and appropriate action to preserve Our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
- 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.

ARTICLE VIII ~ CONTINUATION OF COVERAGE

Some Federal and State Laws may give a Member the right to continue coverage with NHP if s/he would otherwise lose coverage. While a Member is entitled to all of the Benefits under the Federal or State Laws that apply, the Member is not entitled to a duplication of those Benefits.

> ***IMPORTANT:*** *NHP does not administer COBRA/State Continuation rights. For additional information regarding Your Continuation rights, please contact Your employer.*

1) STATE CONTINUATION

This option is available only if the Member has been covered under NHP for at least three (3) consecutive months. A Member may elect this option if:

a) Eligibility for Group coverage terminates due to the employee's loss of eligibility, other than for gross misconduct on the job;
b) The Member is the former spouse of the employee and the marriage ended due to divorce or annulment while Dependent coverage was in effect;
c) The Member is a surviving Dependent spouse or child of an employee who dies while Dependent coverage was in effect.

The Group is required to provide the Member with a written notice of these rights. The Member must receive the notice within five (5) Days after the date the Group knows that the Member's eligibility for coverage will terminate.

The Member has thirty (30) Days from the date of the notice to elect the continuation option and pay the Premium due to the employer. The Subscriber's employer will inform You of the Premium due and the date the Premium must be paid. The Subscriber's employer will send payment to NHP. The Member must complete a new enrollment form if s/he is a former spouse or a surviving Dependent spouse or child.

Coverage under NHP continues under this option until the earliest of the following:

a) The end of eighteen (18) consecutive months from the date the Member elected this option. Upon completion of the eighteen (18) months NHP may require the Member to convert to individual coverage;
b) The date the Member is eligible for similar coverage under another Group medical plan;
c) The end of the last month for which Premium was paid by the Member when due;
d) The date the employee is no longer covered by the plan or replacement Group Policy, if the Member is the former spouse of an employee;
e) The Member establishes residence outside the State of Wisconsin;
f) The date on which the Group terminates coverage under the Policy.

2) FEDERAL CONTINUATION

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with twenty (20) or more employees.

> ***IMPORTANT:*** *COBRA applies to each employer group of a Chamber Association separately. Thus, Members who work for Chamber employers with less than twenty (20) employees are not eligible for COBRA.*

COBRA entitles a Member to continuation of coverage under the Policy if the Member is:

a) A surviving Dependent spouse or child of a Primary Insured who dies while Dependent coverage was in effect;
b) A Dependent child who is no longer considered eligible for coverage.

COBRA also entitles a Member to continuation of coverage under the Policy if eligibility for Group coverage ends because:

a) The Primary Insured's work hours are reduced or s/he is terminated for reasons other than gross misconduct;
b) Of divorce or legal separation while Dependent coverage was in effect;
c) The employee becomes eligible for Medicare, unless the Member is covered by Medicare prior to retirement.

The Member is responsible for notifying the Employer within sixty (60) Days of the dissolution of marriage, legal separation or a child losing Dependent status. If the Member wishes to continue coverage, s/he must complete an election form and submit it to the employer within sixty (60) Days of the later of the date:

a) The Member is no longer covered; or
b) The Member is notified of the right to elect COBRA continuation.

The employer is required to provide the Member with a written notice of these rights. The Member must receive the notice within fourteen (14) Days after the date the Group knows that the Member's eligibility for coverage will terminate.

The Primary Insured's Employer will inform You of the Premium due. The back Premium must be paid within forty-five (45) Days from the date of the election. The Primary Insured's Employer will send payment to NHP. The Member must complete a new enrollment form if s/he is a former spouse or a surviving Dependent spouse or child.

The Member will be responsible for paying any Premiums to the employer for the continuation of coverage.

2) FEDERAL CONTINUATION (continued)

The Member may continue coverage for up to eighteen (18) or thirty-six (36) months, depending on the nature of the qualifying event. A Member who is "disabled" under the Social Security Act, within sixty (60) Days of the qualifying event may be eligible to continue coverage for up to twenty-nine (29) months. COBRA coverage ends at the earliest of:

a) The last day of the eighteen (18), twenty-nine (29), or thirty-six (36) month maximum coverage period, whichever is applicable;
b) The first day (including grace periods, if applicable) on which the Member fails to make timely payment.
c) The date on which the Group ceases to maintain any Group health plan (including successor plans).
d) The first day on which any other Group health plan actually covers the Member.
e) The date the Member is entitled to Medicare Benefits.

3) USERRA COVERAGE

NHP fully adheres to The Uniform Services Employment and Re-Employment Rights Act (USERRA), which requires all employer Groups to provide healthcare coverage during all active military leave to current NHP Members and their Dependents as required by law.

ARTICLE IX ~ EXCLUSIONS AND LIMITATIONS

This Article lists services, treatments, equipment and supplies, and the Benefits that are limited or excluded. NHP will not pay for services, treatment, equipment and supplies that are excluded. NHP will pay for limited Benefits only to the extent and under the circumstances described below. Some of the listed exclusions may be Medically Necessary, but still are not covered under this plan. Others may be examples of services that NHP determines are not Medically Necessary or not medical in nature.

> ***IMPORTANT:*** *NHP will use this Certificate to determine if a service or supply is covered. NHP will not pay for services or supplies that the Certificate does not cover. This is the case even if a Practitioner prescribes, recommends or approves the service or supply.*

NHP will only pay for services or supplies that a provision in this Certificate requires it to cover. NHP will not cover a service or supply that any provision of this Certificate, in this Article or elsewhere, excludes.

Covered Services do NOT include

1. Abortions, the directly intended termination of a pregnancy and all related charges and complications.
2. Acupuncture, acupressure and similar services. Acupuncture is a Covered Service for the treatment of nausea associated with chemotherapy, post-operative nausea, chronic headaches, chronic neck pain, chronic low back pain, and osteoarthritis of the knee.
3. All artificial conception procedures. This includes, but is not limited to:
    - prescriptions;
    - lab and diagnostic procedures;
    - in-vitro fertilization;
    - artificial insemination;
    - intrauterine insemination;
    - micromanipulation procedures of sperm such as intracytoplasmic sperm injection (ICSI);
    - sperm penetration and movement studies;
    - sperm banking;
    - advanced reproductive technologies. These include in-vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT) and gamete intra-fallopian transfer (GIFT) whose primary purpose is to achieve pregnancy;
    - Procedures related to fertility problems that are considered Unproven, Experimental, Investigational or for Research Purposes.
4. Alternative medicine charges including but not limited to acupuncture, acupressure, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, herbal therapy, vitamins or dietary products, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, BEST or AIT therapy, iridology, colonic irrigation, magnetic innervation therapy, electromagnetic therapy, music therapy and neurofeedback.

5. All artificial and animal to human organ transplants. All organ donor services not specifically covered under ARTICLE II ~ BENEFIT PROVISIONS section.
6. Amniocentesis or chorionic villi sampling done solely for sex determination or not Medically Necessary.
7. Any item or supply available over the counter.
8. Any injury or Illness caused by war or to which war contributed.
9. Any services or supplies for Bodily Injuries sustained while the Member is committing or attempting to commit a crime.
10. Any supplies or services furnished for the protection or convenience of or to meet a requirement of third parties. This includes medical, physical, mental health and substance abuse services or examinations. Third parties include, but are not limited to, attorneys, school systems, employers and insurers or court ordered commitments, except as outlined under Benefit Provisions- Preventive Visits. NHP does cover health services mandated by a court as a stipulation of parole, probation, sentencing or any other reason, if Medically Necessary.
11. Any service or expense You incur (a) before Your Effective Date of coverage, (b) after the date Your coverage under this Certificate terminates or (c) after You are disenrolled from NHP.
12. Any treatment that is not Medically Necessary and appropriate. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
13. Any treatment that is not medical in nature or that is solely for the purpose of athletic performance and/or participation. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
14. Any treatment that is provided mainly for the Member's vocation, comfort, convenience, exercise, physical fitness or recreation. Any treatment that is provided mainly as an adaptation of the Member's environment or that is a common household item. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
15. Any treatment that is habilitative in nature. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
16. Any treatment that is used in the absence of a Bodily Injury or Illness. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
17. Any treatment furnished or ordered for a Member by a Family Member or any person residing with the insured including treatment furnished or ordered by the Member. This includes prescriptions, services or supplies. Family Members include Your lawful spouse, child, parent, grandparent, brother, sister or any person related in the same way to Your covered Dependent.
18. Any treatment that is used for hair analysis, hair loss or any form of alopecia. This includes, but is not limited to hair replacements, wigs, toupees and hair replacement

therapies. This applies to any procedure, service, device, supply or drug. It also applies to Durable medical Equipment, prosthetic devices and technology.

19. Any type of holistic or homeopathic treatment.
20. Augmentive and alternative communication aids, such as talk boards. NHP does not cover the fitting of such items. This does not apply to treatment specifically outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate.
21. Autism services not covered include: Acupuncture, Respite care, Custodial Care, Care provided in a residential treatment facility, inpatient treatment, or day treatment facility, Chelation therapy, Child care fees, Cranial sacral therapy, Hyperbaric Oxygen Therapy, Special diets or supplements, Auditory integration training, Facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of a Member's home, and Animal-based therapy including equine therapy and hippotherapy and services rendered by any Practitioner who is not qualified to provide intensive-level services or non-intensive level services.
22. Autopsy.
23. Batteries, unless for an implanted device or specifically outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate.
24. Behavioral training.
25. Health services for injury or Illness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to the plan. Coverage written under such other non-Group insurance may be excess coverage over any other payment. If Benefits subject to this provision are paid, Network Health Plan shall exercise its recovery rights, as provided in this Certificate.
26. The cost of missed appointments.
27. The cost of release and review of medical records, except when requested by NHP.
28. The cost of chelation treatment.
29. The cost of communications, lodging and transport or travel time. The cost of ambulance service, as outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate, is not excluded.
30. Custodial Care.
31. Dental care or treatment. This applies to periodontic care, dentures, mouth guards, osteotomy, teeth whitening and bleaching. This does not apply to treatment specifically outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate.
32. Dental implants. This does not apply to treatment specifically outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate.
33. Glasses or contact lenses. This includes measurement, fitting and adjustment. NHP will cover one (1) basic pair of eyeglasses limited to one (1) lens per surgical eye within a twelve (12) month period after cataract surgery, as outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate. Basic frames and lenses do not include and are not limited to the following items: Blended, no-line progressive lenses, polycarbonate lenses, anti-reflective, scratch resistant and ultraviolet (UV) protection, any coating or lamination applied to lenses, tinting and sunglasses.

34. Influenza vaccination(s) other than inactivated Influenza vaccination given by injection, (e.g. flu mist) unless recommended by the Centers for Disease Control and Prevention (CDC).
35. Human Chorionic Gonadotropin injections.
36. Health club memberships.
37. Health services provided by Non-Participating Providers and Non-Participating Practitioners. This does not apply to:
    - Services provided with NHP's Authorization;
    - Emergency care provided in an Emergency room or Hospital-based Urgent Care Facility when, due to the Member's location when care became necessary, a Participating Provider or Practitioner could not practically furnish the care;
    - Urgent Care provided in an Emergency room or Hospital-based Urgent Care Facility outside NHP's Service Area.
38. Health services for disabilities or conditions related to military service. This applies only if the Member is legally entitled to services provided by a government agency. Government facilities must be reasonably available to the Member. NHP will determine whether services are reasonably available. This exclusion may be limited by Federal law.
39. Health services for job, employment or work related Bodily Injuries or Illnesses for which coverage is:
    - Required under any Worker's Compensation Act or Law;
    - Required under any Occupational Disease Act or Law;
    - Provided under a Workers' Compensation policy.
40. Hearing aid cords.
41. Births at stand-alone birth centers, home births and all related services.
42. Hypnosis therapy.
43. Immunizations and health services for travel, licensing, employment, recreation and insurance purposes.
44. Inpatient Hospital services that NHP or its designee does not certify as being Medically Necessary and appropriate care.
45. Infertility services, supplies, and prescriptions which are not for treatment of Illness or injury (i.e. that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.
46. Kidney disease services for which Medicare provides reimbursement.
47. Lyme disease vaccine.
48. Maintenance Therapy of any kind. This includes, but is not limited to, cardiac rehabilitation, chiropractic, physical, speech and occupational therapy.
49. Marriage counseling.
50. Massage therapy.
51. Medical or surgical procedures that are not Medically Necessary or that are considered Unproven, Experimental, Investigational or for Research Purposes. This applies to complications from such procedures. NHP's Medical Director will make such determinations. NHP will base its decisions on generally accepted standards of the U.S. medical community.

52. Member cost sharing. This applies to the amount of any Deductible, Co-Payments or Co-Insurance. Cost sharing amounts are shown in the Summary of Members Responsibility Table/Summary of Benefits and Coverage and in any Rider attached to this Certificate.
53. Methadone Maintenance Treatment for Opiate Dependence.
54. Models, equipment or devices that have features over and above those that are Medically Necessary for the Member.
55. Motor vehicles or customizing of vehicles. This includes, but is not limited to, lifts for wheelchairs, scooters and stair lifts.
56. Neuropsychological testing for Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.
57. Oral surgery. This includes:
    - Jaw adjustments to correct malocclusion;
    - Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars;
    - Surgical removal of teeth due to anomalies of tooth position of fully erupted teeth;
    - Alveolectomy or alveoplasty;
    - Apicoectomy. (Excision of apex of tooth root.);
    - Treatment of periodontitis and gingivitis;
    - Orthognathic surgery;
    - Osteotomy surgery; and
    - Reconstructive orthognathic surgery.
58. Orthodontic services and surgery except for the treatment of TMD.
59. Out of area services, the need for which could have been foreseen or predicted.
60. Prayer or spiritual healing.
61. Prescription and other drugs. This applies to all over the counter medications. This applies to take home drugs dispensed on Hospital discharge. This does not apply to drugs a Member receives while inpatient or as part of a Home Health Care program.
62. Private Duty Nursing.
63. Private room charges; except as specifically outlined in ARTICLE II ~ BENEFIT PROVISIONS Section of this Certificate.
64. Repairs or replacements of DME, orthotics, prosthetics or prescription drugs due to Accidental loss, theft or negligent misuse.
65. Reversal of voluntarily induced Infertility or any related services or complications.
66. Routine foot care. This includes, but is not limited to, trimming corns and calluses, hypertrophy or hyperplasia of the skin and subcutaneous tissue of the feet and nails. This also includes other hygienic and preventive maintenance care such as cleaning and soaking the foot, use of skin creams to maintain patient's skin tone, and any other service performed in the absence of localized Illness, injury, or symptoms involving the foot. NHP does cover services for a metabolic or peripheral disease or if skin or tissue is infected.
67. Services and supplies for which no charge is made or for which You would not be required to pay if You did not have this coverage.
68. Services for teeth cracked or broken due to biting or chewing.

69. Services solely to improve the Member's appearance. NHP will not pay for services that are not for the correction of a functional defect caused by a Bodily Injury or Illness. This includes Reconstructive, plastic, or Cosmetic Surgery. Psychological impact is not a functional defect caused by a Bodily Injury or Illness.
70. Sex change treatments and procedures.
71. Shoe inserts, unless custom made and Medically Necessary.
72. Sterilizations. This includes, but is not limited to, tubal ligations and vasectomies.
73. Sublingual (under the tongue) allergy testing and treatment.
74. Surgical and non-surgical treatment of the jaw joint. This applies to craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull. However, NHP will cover such treatment if the condition is a consequence of neoplasms, arthritis, ankylosing spondylitis or disseminated lupus erythematous; or if the condition is a consequence of acute dislocation and fractures occurring less than one (1) year before treatment begins. NHP also covers treatment for Temporomandibular Disorder (TMD).
75. Surgery to correct vision. This includes, but is not limited to:
    - Radial Keratotomy (RK);
    - Astigmatic Keratotomy (AK);
    - Automated Lamellar Keratoplasty (ALK);
    - Excimer Laser;
    - Photorefractive Keratotomy (PRK);
    - Phototherapeutic Keratotomy (PTK);
    - Laser assisted Insitu Keratomileusis (LASIK);
    - Corneal modulation; and
    - Refraction Keratoplasty
76. Telephone consultations unless provided through NHP's defined virtual care provider network.
77. Therapy, treatment or services for Developmental or Learning Disability or Delay.
78. Treatment for obesity. Treatment NHP does not cover includes, but is not limited to, weight loss or weight management programs, ileal bypass, gastric bypass or stapling and complications from such procedures, regardless of secondary Benefits resulting from weight loss.
79. Treatment of sexual or erectile dysfunction (including impotence). This includes any procedure, service, supply, drug, device or technology used to treat these conditions.
80. Treatment and/or services related to a non-covered benefit, including complications of a non-covered benefit.
81. Treatment for gambling addiction.
82. Treatment provided for or related to education, vocational rehabilitation, self help or work hardening services. This applies to any such testing, services, supplies or procedures.
83. Treatment and services for Rett's Disorder and sensory integration or defensiveness.
84. Treatment or services furnished and/or billed by an adult or child daycare organization.
85. Treatment or services which are not furnished or supplied by a Provider under the direction of a Practitioner.

86. Vision therapy including eye exercises.
87. Herpes zoster vaccine for Members under the age of fifty (50).
88. Cold laser therapy (also known as Low Level Light therapy) and similar services. Cold laser therapy is excluded except for the treatment of temporomandibular joint disorders (TMD) dysfunction, rheumatoid arthritis, carpal tunnel syndrome, and lateral epicondylitis.
89. Human Papillomavirus Vaccine (HPV) for Members under the age of nine (9) and over the age of twenty-six (26).
90. Coma stimulation.
91. Animal-based therapy including equine therapy or hippotherapy.
92. Childbirth preparation classes including, but not limited to Lamaze, hypnobirthing, and baby care.
93. Vitamins or food supplements.

ARTICLE X ~ COMPLAINT AND GRIEVANCE RESOLUTION

NHP designed this Complaint and Grievance Resolution process to protect the rights of Members.

If You have a question or Complaint about any decision NHP makes, including a Coverage Denial Determination or if You have any other question or concern about NHP, contact a NHP Customer Service Representative. The Customer Service Representative will try to answer Your question or resolve Your concern. If You are not satisfied, You may file a Grievance.

1) COMPLAINTS

A Complaint is a verbal expression by or on behalf of the Member of any dissatisfaction with NHP or its contracted Providers.

2) GRIEVANCES (APPEALS)

A Grievance is a written or electronically submitted expression of dissatisfaction with NHP's administration, Claims practices or provision of services submitted by or on behalf of a Member.

Grievances received by NHP are forwarded to appeals and grievance within the Quality Improvement Department for resolution.

3) GRIEVANCE PROCEDURES

NHP follows procedures designed to provide You a reasonable opportunity for a full and fair review of Your Grievance:

a. You must file a Grievance by sending a written explanation of Your concerns to NHP at the address on the cover page of this Certificate within 3 years, or 1095 days, of receiving notice that Your Claim or service was denied;
b. NHP will acknowledge Your Grievance in writing within five (5) business days of receiving it;
c. NHP will appoint a Grievance committee to review Your Grievance. The committee will not include any person that made the initial benefit determination;
d. NHP will notify You at least seven (7) calendar days in advance of the time and date that the Grievance committee will hear Your case;
e. You have (or a representative You authorized has) the option to appear in person before the Grievance committee to present any information to support Your position, including written comments, documents, records and other information. If You are (or Your authorized representative is) unable to attend, You (or Your authorized representative) may attend by telephone. You (or Your authorized representative) may ask questions of Grievance committee members at that time;
f. NHP will take into account all comments, documents, records, and other information You submit that are relevant to the Claim, without regard to whether NHP received or considered that information in its prior benefit determination;

3) GRIEVANCE PROCEDURES (continued)

g. If Your Grievance concerns a Coverage Denial Determination that is based, in whole or in part, on a medical judgment, the Grievance committee will consult with an independent health care professional. The independent health care professional will have appropriate training and experience in the field of medicine related to the medical judgment. The independent health care professional will not be the same person with whom NHP consulted in the initial Coverage Denial Determination or the subordinate of such person;

h. NHP will notify You in writing of the results of the Grievance review. A member of the Grievance committee will sign the written notice. NHP will send the notice within the time periods outlined below, and according to the procedures described in this Certificate;

Type of Grievance	Initial Time Period	Extended Time Period
Urgent Care Claim	As soon as possible taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the request for review.	None.
Post-Service Claim	Within a reasonable period of time, no later than sixty (60) days after receipt of the request for review.	None.
Pre-Service Claim	Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the request for review.	A thirty (30) day extension, not to exceed a maximum of sixty (60) days.
Grievance not related to Coverage Denial Determination	Within thirty (30) days after receipt of the request for review.	A thirty (30) day extension, not to exceed a maximum of sixty (60) days.

i. If NHP cannot address Your Grievance within the initial time periods described above, NHP will notify You in writing. Your written notice will state why more time is required and when You can expect the matter to be resolved. If more time is required to address Your Grievance, NHP will resolve the matter within the extended time periods described above.

4) EXPEDITED URGENT GRIEVANCE (APPEAL)

If Your Grievance involves clinical urgency, the Grievance will be expedited.

Expedited Grievance means a Grievance where the standard resolution process may include any of the following:

a) Serious jeopardy to the life or health of the enrollee or the ability of the enrollee to regain maximum function;
b) In the opinion of a Practitioner with knowledge of the enrollee's medical condition, the enrollee would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance;
c) It is determined to be an Expedited Grievance by a Practitioner with knowledge of the enrollee's medical condition.

NHP's Quality Improvement Department will determine whether the Claim (Grievance) qualifies as an Urgent Care Claim (Grievance), and, if so, assign a licensed nurse and/or Practitioner to investigate and respond to the Grievance.

NHP's expedited process requires a decision to be made as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receiving the request. The practitioner will be contacted verbally with the initial notification of the decision within the seventy-two (72) hour timeframe. Written notification of the decision will then be provided to the Member and the practitioner no later than three (3) calendar days from the verbal notification.

IMPORTANT: *NHP may obtain medical advice and/or medical reviews when necessary and appropriate to evaluate Your Grievance.*

5) RIGHT TO REQUEST AN INDEPENDENT REVIEW

You may have the right to have an independent review of certain final decisions made by NHP. If You (or a representative on Your behalf) request an independent review, an Independent Review Organization (IRO) will process Your grievance. The only Grievances that are eligible for independent review are Grievances of Coverage Denial Determinations (including expedited reviews of Coverage Denial Determinations) that involve:

- Medical judgment, including NHP's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or NHP's determination that a treatment is Unproven, Experimental, Investigational or for Research Purposes.
- A rescission of Your policy or Certificate.
- Denied coverage for a Non-Participating Provider or a Non-Participating Practitioner, but You feel the clinical expertise of the Non-Participating Provider or the Non-Participating Practitioner is Medically Necessary.

Requests for services that are not included in Your benefit package are ineligible for independent review (including, but not limited to benefit limitations and direct exclusions).

5) RIGHT TO REQUEST AN INDEPENDENT REVIEW (continued)

Generally, You must complete NHP's internal Grievance process before You can initiate an independent review. You do not need to complete the internal Grievance process; however, if Your Coverage Denial Determination qualifies for the Expedited Grievance and You request an immediate independent review. In addition, if You request an immediate independent review, We may agree to proceed if We conclude that it is in everyone's best interests.

To request an independent review, You must send Your written request to NHP within four (4) months of the date on which You receive NHP's written response to Your Grievance or the Coverage Denial Determination, whichever is later. If You do not notify NHP of Your request for independent review within the four (4) months, Your case is no longer eligible for independent review. Your written request must include:

- Your name, address, and telephone number.
- An explanation of Your disagreement with the Coverage Denial Determination.

In an urgent care situation, Your request for independent review does not have to be in writing and will be expedited; You may also request to have the Grievance Committee review an urgent care situation at the same time as the IRO to save time. When NHP receives Your request for independent review, NHP will perform a preliminary review to determine whether Your request is eligible for review. NHP will complete the preliminary review within five (5) business days (as soon as possible for an expedited review) and notify You of its determination within one (1) additional business day (as soon as possible for an expedited review). If Your request is not eligible for independent review, NHP will explain the reasons why it is not eligible and any information You may provide to make Your request eligible. If Your request is eligible for independent review, NHP will randomly assign Your case file to one of three contracted Independent Review Organizations (IROs) to process Your Grievance.

Generally, the IRO's decision is binding on both NHP and You, except to the extent other remedies are available under State or Federal law. If the Coverage Denial Determination involved in the decision relates to the rescission of coverage, however, the decision is not binding on You. In that case, You may be eligible for binding arbitration.

6) BINDING ARBITRATION

If Your Grievance remains unresolved after completion of the Grievance process, You may submit Your Grievance to binding arbitration as allowed by the Wisconsin Arbitration Act.

IMPORTANT: *You are responsible to pay for one-half of the cost of arbitration.*

IMPORTANT: *Grievances that an IRO reviews are not eligible for binding arbitration.*

7) ADVERSE DETERMINATION

Adverse Determination means a determination by or on behalf of NHP to which all the following apply:

7) ADVERSE DETERMINATION (continued)

a) An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed;
b) Based on information provided, the treatment does not meet NHP's requirements for Medical Necessity, appropriateness, health care setting or level of care or effectiveness;
c) Based on information provided, NHP has reduced, denied or terminated treatment or payment for the treatment.

An Adverse Determination includes those in which coverage for a Non-Participating Provider or a Non-Participating Practitioner was denied, but You feel the clinical expertise of the Non-Participating Provider or the Non-Participating Practitioner is Medically Necessary.

OFFICE OF THE COMMISSIONER OF INSURANCE

ARTICLE XI ~ OFFICE OF THE COMMISSIONER OF INSURANCE

OFFICE OF THE COMMISSIONER OF INSURANCE:

If You have questions or concerns with Network Health Plan, do not hesitate to contact the Customer Service Department at 1-800-826-0940 or 920-720-1300.

You may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, to file a Complaint. You may contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or You can call 1-800-236-8517 outside Madison or 608-266-0103 in Madison and request a Complaint form.

ARTICLE XII ~ DEFINED TERMS

Article XII defines terms used in this Certificate.

ABORTION

An operation or other procedure, including but not limited to induction, to terminate pregnancy before the fetus is viable; or an operation or other procedure to terminate pregnancy after the fetus is viable when the operation or procedure is not performed with the intent to treat a pregnant Member's or fetus' functional defect caused by Bodily injury or Illness. Psychological impact is not a functional defect caused by a Bodily Injury or Illness.

ACCIDENT (ACCIDENTAL)

An occurrence which is:

a) Unforeseen; and,
b) Is not due to, or contributed to by, a Sickness or disease of any kind; and,
c) Causes Injury.

ACTIVITIES OF DAILY LIVING

a) Bathing;
b) Dressing;
c) Toileting;
d) Transferring, which is move out of bed, chair, wheelchair, tub or shower;
e) Mobility;
f) Eating;
g) Continence which is voluntary maintaining control of bowel or bladder; in the event of incontinence, maintaining a reasonable level of personal hygiene.

ADVERSE BENEFIT DETERMINATION

A denial, reduction, or termination of or a failure to provide or make payment (in whole or in part) for a benefit. This includes determinations based on eligibility for the health plan, utilization review, experimental or investigational treatments and Medical Necessity or appropriateness.

ALLOWABLE EXPENSE

Allowable Expense is a health care service or expense including Deductibles, Co-Insurance or Co-Payments, that are covered in full or in part by any of the plans covering the Member.

ALLOWED AMOUNT

Maximum amount on which payment is based for covered health care services. If Your Practitioner and/or Provider charges more than the Allowed Amount, You may have to pay the difference. (See Balance Billing.)

DEFINED TERMS

ALTERNATE FACILITY

Is a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

a) Surgical services.
b) Emergency Health Services.
c) Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or services for Substance Abuse Disorders on an outpatient or inpatient basis.

AMENDMENT

Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

ANNUAL DEDUCTIBLE

Is the amount stated in the Summary of Member Responsibility Table/Summary of Benefits and Coverage that each Member is required to pay every Benefit Year before any payment for expenses is made by NHP. NHP will calculate the Annual Deductible based upon the total amount of Allowable Expenses incurred during a Benefit Year. The Member may from time to time be required to submit a copy of certain medical bills for payment for Covered Services.

AUTHORIZATION (AUTHORIZED/AUTHORIZE)

NHP's approval of a Provider's and/or a Practitioner's request for NHP to determine that health care services or supplies for a Member are Medically Necessary and appropriate. If approved, the proposed service or supply is subject to the terms and provisions of this Certificate and the Summary of Member Responsibility Table/Summary of Benefits and Coverage.

BALANCE BILLING

When a Practitioner or Provider bills You for the difference between the charged and the Allowed Amount. For example, if the Practitioner's or Provider's charge is $100 and the Allowed Amount is $70, the Practitioner or Provider may bill You for the remaining $30. A Participating Provider may not Balance Bill You.

BENEFIT YEAR

A Benefit Year refers to a 12-month period during which yearly plan design features such as the Deductible, Out-of-Pocket maximum, and specific benefit maximums accumulate.

BENEFITS

Is Your right to payment for Covered Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including

BENEFITS (continued)

this Certificate, the Summary of Member Responsibility Table/Summary of Benefits and Coverage, and any attached Riders and/or Amendments.

BODILY INJURY

An injury resulting from an Accident.

CERTIFICATE

The Certificate of Coverage issued to the Member. The Certificate indicates the terms, conditions and limitations of NHP's health care coverage.

CLAIM

Is a request for payment or reimbursement for health care services. The request for payment or reimbursement must be submitted on a HIPAA standard professional or institutional Claims format (i.e. UB04, HCFA 1500).

CO-INSURANCE

A percentage of the Allowed Amount a Member must pay for Covered Services after the Deductible is met, if applicable. NHP pays the rest of the Allowed Amount. The Summary of Member Responsibility Table/Summary of Benefits and Coverage sets out what, if any, Co-Insurance a Member must pay.

COMPLAINT(S)

A Complaint is a verbal expression by or on behalf of the Member of any dissatisfaction with NHP or its contracted Providers.

CONCURRENT CARE CLAIM

A request to extend beyond that which NHP has approved a course of treatment furnished over a period of time or number of treatments. A "Concurrent Care Claim" is also a decision by NHP to reduce or terminate an on-going course of treatment that NHP had previously approved.

CONFINEMENT PERIOD

Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, Residential Treatment Facility, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your Practitioner; and discharge there from, or (b) the time spent receiving Emergency Health Services for Illness or Injury in a Hospital. Hospital swing bed and hospital sub-acute Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Member is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement.

CONGENITAL ANOMALY

Is a physical developmental defect that is present at the time of birth.

DEFINED TERMS

CONTRACT YEAR

The Policy period of twelve (12) months following the Policy Effective Date as designated by the employer.

CO-PAYMENT(CO-PAY)

The charge, stated as a set dollar amount, that You are required to pay directly to the Provider for certain Covered Services. The Summary of Member Responsibility Table/Summary of Benefits and Coverage sets out what, if any, Co-Payment a Member must pay. The Summary of Member Responsibility Table/Summary of Benefits and Coverage will also indicate if the Co-Payment would apply to the plan Deductible and/or Out-Of-Pocket Limits.

COSMETIC SURGERY

Any surgery or medical treatment undertaken to improve the Member's appearance or self-esteem, without significantly improving physiological function as determined by NHP. Cosmetic Surgery does not treat a Bodily Injury, Illness or functional bodily impairment.

COVERAGE DENIAL DETERMINATION

Is an Adverse Benefit Determination, an Experimental Treatment Determination, or the rescission of a policy or Certificate.

COVERED SERVICE

Those health services, supplies, or procedures this Certificate and Summary of Member Responsibility Table/Summary of Benefits and Coverage covers. The Covered Service is provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Health Disorder, Substance Abuse Disorders, or their symptoms. Covered Services do not include those provided for the convenience of the Member, Practitioner, facility or any other person.

CUSTODIAL CARE

The provision of room and board, nursing care, personal care or other care designed to assist the Member in the Activities of Daily Living. Custodial Care is care that is not likely to improve a Member's medical condition. Care provided to a Member who has reached the maximum level of recovery is Custodial Care. Such care is custodial even if the level of maintenance care requires services of some skilled health professionals. Custodial Care also includes rest cures, respite care and home care provided by Family Members. NHP's Medical Director will determine whether care qualifies as Custodial Care.

DEDUCTIBLE

Is the amount stated in the Summary of Member Responsibility Table/Summary of Benefits and Coverage that each Member is required to pay for Benefits before any payment for expenses is made by NHP. NHP will calculate the Deductible based upon the total amount of Eligible Expenses incurred during a plan year. The Deductible does not include any amount that exceeds Eligible Expenses. The Member may from time to time be required to submit a copy of certain

DEDUCTIBLE (continued)

medical bills for payment for Covered Services. Only charges for Covered Services satisfy the Deductible.

DEPENDENT

Is the Primary Insured's legal spouse, Your child or the child of the Primary Insured's spouse. The individual must also be a citizen of the United States or a resident legal alien.

The term child includes any of the following:

a) A natural child;
b) A stepchild;
c) A legally adopted child;
d) A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse; or
e) A child of a covered Dependent child (grandchild) until the covered Dependent child who is the parent turns 18.

A child listed above must be under 26 years of age.

A Dependent will also include an unmarried child age 26 or older who meets the following criteria:

a) The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
b) The child is chiefly Dependent on You for support and maintenance;
c) The child's incapacity existed before he or she reached age 26; and
d) Your family coverage remains in force under this Certificate.

Written proof of the child's incapacity and dependency must be furnished to Us within 31 Days of the child attaining age 26, and at any time thereafter, but no more frequently than annually after the initial two year period following the attainment of age 26. You must notify Us immediately of an end to the incapacity or dependency.

A Dependent also included an adult child who meets all of the following:

a) The child is a Full-Time Student, regardless of age, attending an accredited vocational, technical or adult education school, or an accredited college or university; and
b) The child was under age 27 and called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while attending, on a full-time basis, an institution of higher education.

A person is not an eligible Dependent if he or she is on active duty with the military service, including the National Guard or Reserves, other than for duty of less than 30 days.

We may require proof of the adult child's Full-Time Student enrollment on an as-needed basis.

DEVELOPMENTAL OR LEARNING DISABILITY OR DELAY

Any condition that interrupts or delays the sequence and rate of normal growth, development and maturation. The condition may be due to:

a) Congenital abnormality;
b) Trauma;
c) Deprivation; or
d) Disease.

DURABLE MEDICAL EQUIPMENT

Equipment that meets all of the following criteria:

a) Can withstand repeated use.
b) Is not disposable.
c) Is used to serve a medical purpose with respect to treatment of a Sickness, Bodily Injury or their symptoms rather than being primarily for comfort or convenience.
d) Is generally not useful to a Member in the absence of a Sickness, Bodily Injury or their symptoms.
e) Appropriate for treatment of Your Bodily Injury or Illness.
f) Is appropriate for use, and is primarily used, within the home.
g) Is not implantable within the body.
h) Is provided in the most cost effective manner required by Your condition, including, at Our discretion, rental or purchase.

EFFECTIVE DATE

The date that a Primary Insured, or any qualified Dependent, becomes enrolled and entitled to the Benefits specified in this Certificate of Coverage, as shown in the records of NHP.

EMERGENCY

A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

a) Serious jeopardy to the health of the individual;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part; or
d) With respect to a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency Health Services do not include services the Member obtains for his/her convenience or preference.

EMERGENCY HEALTH SERVICES

Are health care services and supplies necessary for the treatment of an Emergency.

EXPERIMENTAL TREATMENT DETERMINATION

NHP's determination that each of the following applies:

a) A proposed treatment has been reviewed by or on behalf of NHP;
b) The treatment was determined to be Experimental;
c) NHP denied the treatment or payment for the treatment.

FAMILY DEDUCTIBLE

If, during a Benefit Year, the total amount of Allowable Expenses incurred and applied toward the Annual Deductible between all Members in a family equals the Family Deductible limit stated in the Summary of Member Responsibility Table/Summary of Benefits and Coverage, no further Deductible will be applied for the rest of that Benefit Year.

FAMILY MEMBER

Family Members include Your lawful spouse, child, parent, grandparent, brother, sister or any person related in the same way to Your covered Dependent.

FULL-TIME STUDENT

A Dependent who is enrolled in 12-15 credits per semester, or as defined by the institution the student is attending.

GROUP

The employer, association, union or trust to which NHP issued the Policy. The Policy is the contract that entitles Members to the coverage described in this Certificate.

HABILITATIVE SERVICES

Habilitative Services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HOME HEALTH AGENCY

Is a program or organization licensed by law to provide health care services in the home.

HOME HEALTH CARE

Care and treatment the Member needs, but that the Member's immediate family is not able to provide or may only provide with undue hardship. The Member's immediate family includes other persons who reside with the Member. A state licensed or Medicare certified home health agency or certified rehabilitation agency must manage the care. Home Health Care consists of one or more of the following:

a) Part-time or intermittent nursing care;
b) Physical, respiratory, speech, occupational therapy;

HOME HEALTH CARE (continued)

c) Nutritional counseling;
d) Part-time or intermittent home health aide services;
e) Medical supplies, drugs;
f) Laboratory services;
g) Evaluation of the need for and the development of a plan for home health services.

HOSPICE

Services within an integrated program, the primary purpose of which is to provide comfort and support to the terminally ill and their families on a 24-hours a day, 7-day a week basis. Services include physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate Family Members while the Member is receiving hospice care. A licensed public agency or private entity must provide the services. Services may be furnished in a Hospice facility housed in a Hospital, a separate Hospice unit or in the patient's home. A Hospice facility housed in a Hospital must be in a separate and distinct area.

HOSPITAL

A facility that is operated as required by law and that meets both of the following:

a) It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Practitioners.
b) It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS

A disturbance in function or structure of the Member's body that causes physical signs or symptoms. An Illness, if left untreated, will cause the health of the Member's body structure or system to deteriorate.

INFERTILITY

The failure of a couple to conceive a pregnancy after trying to do so for at least one full year.

INJURY

Bodily damage, other than Sickness, including all related conditions and recurrent symptoms resulting from an Accident.

IN-NETWORK

The Practitioners and Providers NHP has contracted with to provide Covered Services.

INPATIENT REHABILITATION FACILITY

Is a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as licensed by law.

INPATIENT STAY

Is an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

INTENSIVE OUTPATIENT TREATMENT

Is a structured outpatient Mental Health and Substance Abuse Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per Day, two or more Days per week.

MAINTENANCE THERAPY

Ongoing therapy for which only minimal rehabilitative gains can be shown. Such therapy is furnished after the acute phase of a Bodily Injury or Illness has passed. Therapy furnished after a patient's recovery reaches a plateau or slows or ceases entirely. NHP determines that therapy is Maintenance Therapy by reviewing a Member's case history or the treatment plan the Provider submits.

MAXIMUM ALLOWABLE FEE

The maximum amount allowed for charges for covered health care services based upon:

a) Our methodology guidelines;
b) Pricing guidelines of any third party that is responsible for repricing a Claim;
c) The negotiated rate determined by Us in accordance with the applicable contract between Us and a health care Provider or Practitioner; or
d) Maximum Out-of-Network Allowable Fee.

The Maximum Allowable Fee may be less than the amount billed.

Upon written or oral request from You for Our Maximum Allowable Fee for a health care service and if You provide Us with the appropriate billing code that identifies the health care service (e.g., CPT codes, ICD-9 or ICD-10 codes, or hospital revenue codes) and the heath care Provider's or Practitioner's estimated fee for that health care service, We will provide You with any of the following:

a) A description of Our specific methodology including, but not limited to, the following:

    1. The source of the data used, such as Our Claims experience, an expert panel of Providers or Practitioners, or other sources;
    2. The frequency of updating such data;
    3. The geographical area used;

MAXIMUM ALLOWABLE FEE (continued)

4. If applicable, the percentile used in determining the Maximum Allowable Fee; and
5. Any supplemental information used in determining the Maximum Allowable Fee.

b) The Maximum Allowable Fee determined by Us under Our guidelines for a specific health care service provided to You. That may be in the form of a range of payments or maximum payment.

MAXIMUM OUT-OF-NETWORK ALLOWABLE FEE

The amount We develop for covered health care services provided by a Non-Participating Provider or a Non-Participating Practitioner and incurred while this Certificate is in effect.

The amount is determined by Us based on the following:

a) When covered health care services are received from a Non-Participating Provider or a Non-Participating Practitioner, the Maximum Allowable Fee is based on the lesser of:

1. Amounts billed by a health care provider; or
2. Amounts charged by health care providers for similar health care services in a geographical area; or
3. Fee(s) that are negotiated with the Non-Participating or a Non-Participating Practitioner; or
4. A percentage, as determined by Us, of the published rates allowed for the zip code in which services were rendered by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar health care service, or

a. When a rate is not published by CMS for the health care service, We use an available gap methodology to determine a rate for the health care service as follows:

i. For health care services other than Practitioner administered pharmaceuticals, We use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the health care service. The relative value scale currently used is created by OPTUMInsight. If the OPTUMInsight relative value scale becomes no longer available, We will use a comparable scale.

ii. For Practitioner administered pharmaceuticals, We use a gap methodology that is similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale prices for pharmaceuticals. This methodology is created by Us based on an internally developed pharmaceutical pricing resource.

b. When there is not an available or applicable CMS rate and a gap methodology does not apply to the health care service, the Maximum Out-of-Network Allowable Fee is based on a percentage, as determined by Us, of the health care provider's charge.

MAXIMUM OUT-OF-NETWORK ALLOWABLE FEE (continued)

b) We annually update Maximum Out-of-Network Allowable Fees when updated data from CMS becomes available. Amounts used are the rates established by CMS on January 1 of the current year. Updates to the Maximum Out-of-Network Allowable Fees are typically implemented within 30 to 90 days after CMS updates its data.

c) There may be times when You receive Participating Provider Benefits from a Non-Participating Provider, such as in an Emergency situation. If a negotiated rate is not available, We will seek to reimburse the Non-Participating Provider using the Maximum Out-of-Network Allowable Fee.

MAXIMUM POLICY BENEFIT

The total amount of expenses paid for Covered Services while the Member is eligible for coverage under this Certificate, including applicable Riders and the Summary of Member Responsibility Tables/Summary of Benefits and Coverage. The Maximum Policy Benefit includes both medical and pharmacy Covered Services unless otherwise specified in the Summary of Member Responsibility Tables/Summary of Benefits and Coverage.

MEDICAL DIRECTOR

The Practitioner NHP selects to direct its medical affairs.

MEDICALLY NECESSARY (MEDICAL NECESSITY)

Health care services or supplies that:

a) Are necessary to identify, diagnose or treat a Bodily Injury or Illness;
b) Are consistent with the Member's diagnosis in accord with generally accepted standards of the medical community;
c) Are provided in the least intense, most cost effective setting or manner needed for the Member's Bodily Injury or Illness;

MEDICARE

Title XVIII (Health Insurance Act for the Aged) of the U.S. Social Security Act, as amended.

MEMBER

A person covered under this health insurance policy.

MENTAL HEALTH DISORDER

A mental or emotional disease or disorder to such an extent that a Member so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or the community. Mental disorder includes psychiatric illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Mental disorder doesn't not include autism spectrum disorder.

MENTAL HEALTH SERVICES

Are Covered Services for the diagnosis and treatment of Mental Health Disorders. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service.

NETWORK

The Practitioners and Providers We have contracted with to provide Covered Services in Our Network.

NHP

Network Health Plan.

NHIC

Network Health Insurance Corporation.

NON-PARTICIPATING, PROVIDER, PRACTITIONER OR HOSPITAL

The absence of any contract with NHP to provide Covered Services to Members under this Certificate.

OUT-OF-POCKET LIMIT

The maximum amount stated in the Summary of Member Responsibility Table//Summary of Benefits and Coverage, which must be paid in Annual Deductible and Co-Insurance amounts, by one Member or between all Members of a family, every Benefit Year. Once the Out-of-Pocket Limit is reached, the covered percentage will increase to 100% of the allowable (unless specifically stated otherwise in the Summary of Member Responsibility Table/Summary of Benefits and Coverage) for the rest of that Benefit Year. Expenses incurred for health care services not covered by Us, Your Premium, or expenses over and above the Maximum Allowable Fee (Balance-Billed charges) do not count towards the Member's Out-of- Pocket Limit.

PALLIATIVE CARE

Care focused on preventing or relieving pain and suffering. The goal is to improve comfort and quality of life for people with a life-threatening or life-limiting Illness while receiving active treatment. Palliative Care may include but is not limited to services for pain, fatigue, anxiety, difficulty breathing, and nausea.

PARTICIPATING PROVIDER, PRACTITIONER OR HOSPITAL

Subject to a contract with NHP to provide Covered Services to Members under this Certificate.

POLICY

The entire agreement issued by NHP to the Group sponsored by an employer, union or trust that includes all of the following

POLICY (continued)

a) The Group Policy.
b) This Certificate.
c) The Summary of Member Responsibility Table.
d) Summary of Benefits and Coverage
e) The Group's application.
f) Riders.
g) Amendments.

These documents make up the entire agreement that is issued to the Group.

POST-SERVICE CLAIM

A Claim for Covered Services that have been furnished.

PRACTITIONER

An individual licensed by the state in which he/she practices within the scope of his/her license to furnish health care. A Practitioner may be a Medical Doctor, Osteopath, Podiatrist, Audiologist, Physician Assistant, Registered Nurse Midwife, Nurse Practitioner or Chiropractor.

PREMIUM

The monthly fees charged by NHP to the Primary Insured or the Group for the Benefits set out in this Certificate.

PRE-SERVICE CLAIM

A request for a Prior Authorization to cover all or part of the services to be furnished.

PRIMARY CARE PRACTITIONER (PCP)

A PCP directs and coordinates a Member's health care. The PCP provides routine care, coordinates needed specialty care and assists Members in obtaining Authorizations from NHP. A PCP is a Practitioner specializing in family medicine, general medicine, internal medicine or general pediatrics.

PRIMARY INSURED(S)

A person who is eligible for and enrolled in the Group's medical Benefits plan. The person must be a full time (working at least 30 hours per Week at the Group), permanent employee.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED)

NHP's approval, prior to a service being given, of a Member Provider's and/or a Practitioner's request for NHP to deem health care services or supplies for a Member are Medically Necessary and appropriate. The proposed service or supply, once approved, is subject to the terms and provisions of this Certificate and the Summary of Member Responsibility Table/Summary of Benefits and Coverage.

PRIVATE DUTY NURSING

Is nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

a) No skilled services are identified.
b) Skilled nursing resources are available in the facility.
c) The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

The service is provided to a Member by an independent nurse who is hired directly by the Member or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

PROVIDER(S)

A licensed health care institution certified or licensed by an appropriate state body. A Provider may be a Hospital, Skilled Nursing Facility, rehabilitation facility or supplier.

RECONSTRUCTIVE SURGERY

A procedure to improve or repair an abnormal condition of a body part.

REHABILITATION SERVICES

Therapy to restore lost function following disease, Illness or injury. Rehabilitation means to restore ability to function in a normal or near normal manner.

RESIDENTIAL TREATMENT FACILITY

A facility which provides a program of effective Mental Health and Substance Abuse Services treatment and which meets all of the following requirements:

a) It is established and operated in accordance with applicable state law for residential treatment programs.
b) It provides a program of treatment under the active participation and direction of a Practitioner.
c) It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the Member.
d) It provides at least the following basic services in a 24-hour per day, structured milieu:

    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

RIDER

Any attached written description of additional Covered Services not described in this Certificate. Covered Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

ROUTINE PATIENT CARE

Routine patient care means all health care services, items and drugs that are typically provided in health care, including those provided to a Member during the course of treatment in a cancer trial (all phases) for a condition or any of its complications and those services are consistent with the usual and customary standard of care including the type and frequency of any diagnostic modality.

Routine patient care **does not** include:

- the health care service, item or investigational drug that is the subject of the cancer clinical trial.
- 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 Member.
- investigational drugs or devices that have not been approved for market by the FDA
- transportation, lodging, food or other expenses for Member of a Family Member or companion of the Member that are associated with travel to or form a facility providing the cancer clinical trial.
- any services, items or drugs provided by the cancer clinical trial sponsors free of charge.
- any services, items or drugs eligible for reimbursement by a party other than the insurer.

SEMI-PRIVATE ROOM

Is a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

SERVICE AREA

The geographic area We service and for which NHP is licensed by the appropriate regulatory agency(ies). Contact us or log onto www.networkhealth.com then click the link for the Service Area Map to determine the exact geographic area We serve. The Service Area may change from time to time.

SICKNESS

Is a physical Illness or disease. The term Sickness as used in this Certificate does not include Mental Health or Substance Abuse Disorders, regardless of the cause or origin of the disorder.

SKILLED NURSING FACILITY

A facility that:

a) Is primarily engaged in providing skilled nursing care and related services on a twenty-four (24) hours a day basis to inpatients requiring medical or skilled nursing care; and,
b) Is qualified to participate under Medicare; and,
c) Is licensed by the State of Wisconsin.

SPECIALIST

A Practitioner who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

SUBSTANCE ABUSE DISORDER

Alcohol, drug and chemical abuse, overuse or dependency disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services or disorders are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

SUMMARY OF MEMBER RESPONSIBILITY TABLE/SUMMARY OF BENEFITS AND COVERAGE

The table outlining the Member cost sharing terms and other terms of this Certificate.

TELEMEDICINE

Telemedicine provides medical services equivalent to a face-to-face visit and seeks to improve a member's health by allowing for two-way, real time interactive communication between the member and the provider at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes audio and video. Telemedicine does not include email messages, text messages, fax or mail.

TOTAL DISABILITY OR TOTALLY DISABLED

A person is Totally Disabled when, due to an Illness or Accidental injury:

a) The person is the Primary Insured who is unable to engage in any occupation. The Primary Insured may not engage in any gainful occupation during a period of Total Disability;
b) The person is a Member who is not the Primary Insured and who is unable to engage in any normal activity of a person in good health of the same age and sex.

A Member's Practitioner will determine whether the Member is Totally Disabled in conjunction with the NHP Medical Director.

TRANSITIONAL CARE

Mental Health and Substance Abuse Disorders provided in a less restrictive manner than inpatient Hospital services but more intensive than outpatient services. This includes adult, Child and adolescent day treatment.

UNPROVEN, EXPERIMENTAL, INVESTIGATIONAL OR FOR RESEARCH PURPOSES

Treatments, procedures, services, supplies, drugs, devices or technologies ("Treatments") that are not known to be safe or effective or that are used in a way that deviates from generally accepted standards of the U.S. medical community. NHP's Medical Director or designee will determine, in its sole discretion, if a treatment qualifies.

NHP will base its determination on:

a) Reliable evidence showing that the Treatment:

- Is the subject of an ongoing Phase I or Phase II clinical trial;
- Is the research, experiment, study or investigational arm of an ongoing Phase III clinical trial; or
- Is otherwise under study to determine its maximum tolerated dose, its toxicity, its efficacy or safety or its efficacy compared with a standard means of treatment or diagnosis.

b) Whether the Treatment is related to or involves a research protocol. The purpose of such a protocol must be primarily to determine the safety or effectiveness of a Treatment. This includes, but is not limited to, a protocol of the U.S. Department of Health and Human Services (HHS) or any of its Agencies, Bureaus, Institutes or Divisions.
c) Whether an Institutional Review Board (IRB) acting for the treating institution must review and approve the Treatment on an individual basis. An IRB is any person or group of persons charged with deciding whether the treating institution will or may be used to provide a particular Treatment. Your treating Practitioner is not an IRB.
d) Whether any consent or release HHS or the U.S. Food and Drug Administration (FDA) requires the Member to sign describes the Treatment as Experimental, Investigational, or for Research Purposes. This applies to any consent or release that a person acting on behalf of the Member must sign.
e) Whether the Treatment is any drug or device that the FDA must, but at the time the drug or device is furnished, has not approved for marketing.
f) Reliable evidence showing that the prevailing opinion among experts regarding the Treatment is that further studies or clinical trials are needed to show it is safe and reliable. A Treatment is not safe and reliable if more studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its efficacy, its safety or its efficacy as compared with standard means, treatment or diagnosis.

Reliable evidence includes, but is not limited to, peer-reviewed medical literature and technology assessment organizations.

URGENT CARE

Urgent Care is care for the sudden onset of Bodily Injury or Illness that does not qualify as an Emergency. Services for care that You need before You can set up a routine doctor visit are Urgent Care. Examples of Urgent Care situations are sprains, non-severe bleeding, minor cuts and burns.

URGENT CARE CLAIM

A request for an Authorization to cover health care services:

a) That are necessary to avoid serious jeopardy to the life or health of the Member or the inability of the Member to regain maximum function;
b) Without which, in the opinion of a physician with knowledge of the Member's medical condition, the Member would be subject to severe pain that cannot be adequately managed; or,
c) The Claim for which a physician with knowledge of the Member's medical condition determines to be an Urgent Care Claim.

URGENT CARE FACILITY

An Urgent Care Facility is a facility that provides for the delivery of Urgent Care Services. An Urgent Care Facility generally provides unscheduled, walk-in care. An Urgent Care Facility may be Hospital-based or non-Hospital based.

NOTES

network health

NETWORK HEALTH PLAN (NHP)

FAMILY PLANNING RIDER (Rider)

Notwithstanding anything in your Certificate of Coverage (Certificate) to the contrary, it is hereby understood and agreed that your Certificate to which this Rider is attached is amended to include family planning health care benefits as set forth below:

I. ELIGIBILITY

All Members are eligible for family planning health care benefits under this Rider.

II. EXCLUSIONS

The following family planning benefits are not covered under this Rider:

A. Services excluded and/or limited in the Certificate and those specifically described in Exclusions and Limitations, except as specifically stated in this Rider.

B. Services not provided in full compliance with the health services program defined in the Certificate, Obtaining Health Services.

C. Donor sperm procurement, sperm washing, banking, counting, analysis, sperm transport and storage costs.

D. Reversal of voluntary sterilization, including but not limited to, vasectomy reversals and tubal ligation reversals, and all related charges and complications thereof.

E. Directly intended termination of a pregnancy and all related charges and complications thereof.

III. COVERED SERVICES

Covered Services under this Rider include:

A. Voluntary sterilization procedures which include tubal ligations and vasectomies, when provided by a Participating Practitioner or Provider.

B. NHIC approved female contraceptives including over the counter (OTC) products, self-administered contraceptive medications and devices when listed in the Preferred Drug List and purchased from a Participating pharmacy with a valid prescription are covered at no cost.

C. The administration of approved female contraceptives in the Practitioner's office. The administration fee(s) are covered at no cost. Cost sharing will apply for the removal of Intrauterine Device (IUD). The fee(s) for the approved contraceptive(s) are covered at no cost.

HMO plans underwritten by Network Health Plan
POS plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan

D. All services must be received in full compliance with the health services program defined in the Certificate, Obtaining Health Services.

This Rider is made part of the Certificate as of January 1, 2013 or your coverage Effective Date whichever is later. This Rider terminates concurrently with the date your coverage under the Certificate ends. Nothing in this Rider shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Certificate, other than as stated above.

network health

BPL 80092– HMO
PRESCRIPTION BENEFIT SUMMARY OF MEMBER RESPONSIBILITY TABLE

$2,000 per individual / $4,000 per family combined medical and prescription out-of-pocket limit

NOTE: Copayments will apply towards your out-of-pocket limit. Upon reaching the out-of-pocket limit, prescription drugs, insulin, diabetic supplies and specialty products will be covered at 100%.

NOTE: Defined drugs listed in the Value Based Program List are subject to a $0 copayment

PRESCRIPTION DRUGS, APPROVED CONTRACEPTIVES, INSULIN, AND DIABETIC SUPPLIES:	
a. Retail Pharmacy or administered in the practitioner's office, outpatient facility or in the home as indicated in your Medical Summary of Member Responsibility Table	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating practitioner and dispensed through a NHP participating retail pharmacy or administered in the outpatient or home setting as indicated in your Medical Summary of Member Responsibility Table: Tier 1 $20 copayment per prescription or refill Tier 2 $40 copayment per prescription or refill Tier 3 $60 copayment per prescription or refill Diabetic supplies refers to, for example, alcohol swabs/wipes, lancets, lancet devices, insulin syringes and needles, glucose monitors/meters, glucose control solutions, and blood and urine glucose and ketone test strips. All prescriptions, or refills, can be dispensed in quantities up to a 31 day supply. In addition: • Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost. • Approved contraceptives administered in the office for contraceptive purposes are covered at no charge. • Insulin and diabetic supplies can be filled in quantities up to a 91 day supply (copayment required for each 31 day supply) For insulin pump supplies, please refer to your medical supply benefit listed on your Medical Summary of Member Responsibility Table.
b. Mail Order Pharmacy	Prescription drugs, insulin, and diabetic supplies prescribed by a NHP participating practitioner and dispensed through a NHP participating mail order pharmacy in quantities up to a 91 day supply: Tier 1 $ 55 copayment per prescription or refill Tier 2 $105 copayment per prescription or refill

	Tier 3 $180 copayment per prescription or refill NOTE: Preferred Specialty Products and Non-Preferred Specialty Products are not available through the mail order pharmacy. • Approved contraceptives including over the counter (OTC) products listed in the Preferred Drug List can be filled in quantities up to an 84 day supply at no cost.
SPECIALTY PRODUCTS:	
c. Specialty Pharmacy or administered in the practitioner's office, outpatient facility or in the home as indicated in your Medical Summary of Member Responsibility Table	Specialty Products prescribed by a NHP participating practitioner and dispensed through a NHP participating specialty pharmacy or administered in the outpatient or home setting as indicated in your Medical Summary of Member Responsibility Table: • Specialty prescriptions, or refills, can be dispensed through a NHP participating specialty pharmacy in quantities up to a 31 day supply. Preferred Specialty Products (Tier 4) $ 60 copayment per prescription or refill Non-Preferred Specialty Products (Tier 5) $100 copayment per prescription or refill

All benefits are subject to the terms, limitations and exclusions of the Certificate of Coverage. Please refer to your Certificate of Coverage, Preventive Coverage or Preventive Services Guide, and any applicable Riders for detailed benefits information, eligible services and coverage guidelines. Network Health Plan's coverage includes benefits for all State of Wisconsin and Federal mandated benefits.

If the practitioner indicates "Dispense As Written", or if the member requests the brand name product for a medication where a generic is available, the member must pay the applicable copayment/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name product and the generic product up to a maximum of $200 per month's supply. The ancillary charge will not count towards the out-of-pocket limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

To receive a copy of the Network Health Plan Preferred Drug List, please call Customer Service at 1-800-826-0940, or visit www.networkhealth.com.

2018 NETWORK HEALTH STANDARD VALUE-BASED PRESCRIPTION DRUG LIST

ANTIDEPRESSANT

- Bupropion
- Bupropion SR
- Bupropion XL
- Citalopram
- Escitalopram
- Fluoxetine
- Paroxetine
- Sertraline
- Venlafaxine
- Venlafaxine ER Capsules

ANTIDIABETES

- Glipizide
- Glipizide-SR
- Glipizide-Metformin
- Glyburide
- Glyburide-Metformin
- Metformin
- Metformin-SR
- Pioglitazone
- Pioglitazone-Metformin

CHOLESTEROL LOWERING

- Atorvastatin
- Fenofibrate
- Gemfibrozil
- Lovastatin
- Pravastatin
- Rosuvastatin
- Simvastatin

BLOOD PRESSURE CONTROL/ CARDIOVASCULAR

- Amlodipine
- Atenolol
- Bisoprolol
- Carvedilol
- Diltiazem
- Diltiazem SR
- Diltiazem CD
- Felodipine
- Metoprolol
- Metoprolol HCTZ
- Metoprolol SR
- Nadolol
- Nifedipine
- Nifedipine SR/ER
- Propranolol
- Propranolol LA
- Verapamil
- Verapamil-SR

BLOOD PRESSURE CONTROL

- Amlodipine-Benazepril
- Atenolol-Chlorthalidone
- Benazepril
- Benazepril-HCTZ
- Bisoprolol-HCTZ
- Candesartan
- Candesartan-HCTZ
- Captopril
- Captopril-HCTZ
- Chlorthalidone
- Clonidine
- Doxazosin
- Enalapril
- Enalapril-HCTZ
- Fosinopril
- Fosinopril-HCTZ
- Furosemide
- Hydrochlorothiazide (HCTZ)
- Hydralazine
- Indapamide
- Irbesartan
- Irbesartan-HCTZ
- Lisinopril
- Lisinopril-HCTZ
- Losartan
- Losartan-HCTZ
- Metolazone
- Prazosin
- Propranolol-HCTZ
- Quinapril
- Quinapril-HCTZ
- Ramipril
- Spironolactone
- Spironolactone-HCTZ
- Telmisartan
- Terazosin
- Torsemide
- Triamterene-HCTZ
- Valsartan
- Valsartan-HCTZ

Prescription Coverage

1570 MIDWAY PLACE
P.O. BOX 120
MENASHA, WI 54952
855-275-1400 OR 920-720-1400

Network Health Plan ("NHP")

PRESCRIPTION DRUG (RX) RIDER

It is understood and agreed that prescription drug benefits shall be defined and provided under the NHP Health Services Policy and Certificate of Coverage in accordance with the terms and conditions of this Rider, as set forth below:

I. ELIGIBILITY: All Members are eligible for covered prescription drug benefits under the terms and conditions of this Rider.

II. COVERED SERVICES: Covered prescription drug benefits provided under this Rider include FDA approved prescription drugs dispensed under the NHP guidelines including NHP's Preferred Drug List, and Specialty Products Designation as applicable, and are:

A. Dispensed pursuant to the prescription of an appropriately licensed Participating or Authorized Practitioner;

B. Prescription drugs not designated as Specialty Products filled at or administered by a Participating Pharmacy, Practitioner's office, home infusion, in the home, outpatient facility or through a Participating mail order pharmacy program that is appropriately licensed to dispense drugs in the United States by the Federal Drug Enforcement Agency and the State;

C. Designated as a Specialty Product and dispensed at a Participating Specialty Pharmacy or administered by a Practitioner's office, home infusion, or outpatient facility;

D. Received in full compliance with Article III-Obtaining Health Services of the Certificate of Coverage;

E. Medically Necessary and appropriate.

III. PAYMENT: Prescription drugs, including Specialty Products which are subject to a Member Co-Payment per drug and/or Co-Insurance and/or Deductible and/or Maximum Policy Benefit as specified in your Summary of Member Responsibility Table, the Prescription Benefit Summary of Member Responsibility Table and the Preferred Drug List, shall be covered under this Rider and Certificate of Coverage.

IV. LIMITATIONS: Prescription drug benefits covered under this Rider are subject to the following limitations:

A. Initial prescriptions or prescription refills obtained from a Participating Pharmacy or Participating Specialty Pharmacy will be covered up to the limits outlined in your Summary of Member Responsibility Table, the Prescription Benefit Summary of Member Responsibility

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Table and the Preferred Drug List and in accordance with directions from the prescribing Practitioner;

Initial prescriptions or prescription refills obtained from a Participating mail order pharmacy program will be covered up to the limits outlined in your Summary of Member Responsibility Table, the Prescription Benefit Summary of Member Responsibility Table and the Preferred Drug List and in accordance with directions from the prescribing Practitioner;

B. If a Member or Practitioner requests a brand name drug when an NHP approved generic drug is available, ***the Member*** is responsible for the ancillary fee which is the applicable level of Co-Payment and/or Co-Insurance and/or Deductible plus the difference in cost between the generic equivalent and the brand name drug up to a maximum of $200 per month's supply;

C. Prescription refills are covered only after seventy-five percent (75%) of the previously dispensed amount is used;

D. In Emergency conditions, drugs may be prescribed by a Non-Participating Practitioner and dispensed through a Non-Participating Pharmacy;

E. HIV treatment drugs will be covered if they are:

(a) Prescribed by a Participating Practitioner and, either
(b) Approved by the Food and Drug Administration ("FDA"); or
(c) In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.

F. Certain drugs (agents, medications, components) are determined and listed by NHP's Pharmacy and Therapeutics (P&T) Committee to have an increased potential for improper use, misuse, or abuse. These drugs require Prior Authorization by NHP's Health Services Department. A listing of the drugs are provided to NHP Practitioners and are also included in the NHP enrollment packet. Prior Authorization must be requested by the Member or their treating Practitioner before the drugs will be considered covered under this Prescription Drug Rider. Drugs may be deleted from the list and other drugs may be added at any time based on the decisions of the P&T Committee;

G. Products designated as Specialty Products on NHP's Preferred Drug List will be covered subject to the terms and limitations specified in your Summary of Member Responsibility Table, the Prescription Benefit Summary of Member Responsibility Table and the Preferred Drug List.

V. EXCLUSIONS: The following prescription drug benefits will not be covered under the Certificate of Coverage or this Rider.

A. Over the counter medications and supplies unless specifically listed in the most recent edition of the Preferred Drug List; prescription drug products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent unless specifically listed in the most recent edition of the Preferred Drug List; Certain drug products that we have determined are therapeutically equivalent to an over-the-counter drug;

B. Drugs prescribed for treatment of Infertility, unless otherwise provided by a valid Rider to the Certificate of Coverage;

C. Experimental or other FDA approved drugs including compounded medications which are to be used for experimental purposes or unapproved routes of administration, except for HIV treatment drugs that are;

(a) Prescribed by a Participating Practitioner and, either
(b) Approved by the Food and Drug Administration ("FDA"); or
(c) In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.

D. Prescriptions or refill prescriptions required by a Member because of theft, damage or loss of the prescription;

E. Prescriptions or refills exceeding dispensing limitations, for vacation, travel, or other periods of extended duration, unless Prior Authorized by NHP;

F. Take-home drugs are not covered if dispensed prior to your release from confinement from Home Health Care services, inpatient services, or Skilled Nursing Facility. This *does not* apply to drugs a Member receives while an inpatient, as part of an Authorized Home Health Care program, while a resident in a Skilled Nursing Facility or to non-Specialty Products if administered in the Practitioners office.

G. Contraceptive drugs and devices (with the exception of Diaphragms), unless provided for by a valid Family Planning Rider;

H. Prescription drug products dispensed outside the United States, except as required for Emergency treatment;

I. Prescription drug products furnished by the local, state or federal government. Any prescription drug product to the extent payment or benefits are provided or available for the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

J. Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

K. Any product dispensed for the purpose of appetite suppression or weight loss.

L. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than items specifically stated as covered in the PDL;

M. General vitamins, except the following which require a prescription order and are not available in a therapeutically equivalent over-the-counter formulation: prescription prenatal vitamins, vitamins with fluoride, and single entity vitamins;

N. Unit dose packaging of prescription drug products;

O. Medications used for cosmetic purposes;

P. Prescription drug products, including new prescription drug products or new dosage forms, that we determine do not meet the definition of a Covered Service;

Q. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. food and Drug Administration (FDA)*, and not otherwise excluded from coverage by NHP as experimental, and requires a prescription order; Compounded drugs that are available as a similar commercially available prescription drug product;

R. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

S. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease including prescription medicinal food products, even when used for the treatment of Sickness or Injury.

T. Prescription drug products that have not underwent current FDA approval process may not be covered as determined by the Network Health Pharmacy and Therapeutics Committee. These drugs may also be known as non-FDA approved drugs or DESI drugs (Drug Efficacy Study Implementation).

VI. INTERPRETATIONS OF CERTIFICATE: Except as expressly provided above by this Rider, or by other Riders which shall be made part of the Certificate of Coverage, the terms and conditions of the Certificate of Coverage control and remain the same and are in full force and effect.

VII. DEFINITIONS

SPECIALTY PRODUCT: NHP's Pharmacy & Therapeutics Committee may designate pharmaceutical products as Preferred Specialty Products and Non-preferred Specialty Products. These products will be covered as Tier 4 and Tier 5 respectively on your Summary of Member Responsibility Table, the Prescription Benefit Summary of Member Responsibility Table and the Preferred Drug List. Designation will be based on method of administration and/or cost. Pharmaceutical products that have been designated as Specialty Products will be indicated on NHP's Preferred Drug List.

OVER THE COUNTER MEDICATION: An over the counter medication is a medication that is not a prescription drug, or a medication whose ingredient(s) are available without a prescription.

PARTICIPATING PHARMACY / PARTICIPATING SPECIALTY PHARMACY: A pharmacy that has a contract to provide Benefits to You or Your covered Depends under this rider.

PREVENTIVE DRUGS: Medications that are used for the prevention of certain medical conditions.

TIER 0 DRUGS: Preventive Drugs

TIER 1 DRUGS: Preferred prescription drugs consisting primarily of generic drugs and some brand name drugs based on their effectiveness and cost.

TIER 2 DRUGS: Preferred prescription drugs consisting primarily of preferred brand name drugs and some generic drugs based on their effectiveness and cost.

TIER 3 DRUGS: Non-preferred prescription drugs consisting primarily of non-preferred brand name drugs and some generic drugs based on their effectiveness and cost.

TIER 4 DRUGS: Preferred Specialty Products.

TIER 5 DRUGS: Non-preferred Specialty Products.

Find Drugs and Pharmacies

With Network Health, getting the drugs you need is easier than pronouncing them.

We work with CVS/caremark to make your pharmacy and drug coverage straightforward. Drug coverage is included with your plan, and information your pharmacy will need is printed on your Network Health ID card.

Are my drugs covered?

The Network Health **Preferred Drug List** is a list of drugs that we cover. The list is sometimes also called a formulary. It includes the most common covered medications with information about their cost, tier and any restrictions.

View our drug list

Go to **networkhealth.com** and click **Member Sign In** in the upper left corner. Sign in and click **CVS/caremark** under **My Health** to enter the CVS/caremark portal. Once logged in, click **Covered Drug List** under **My Plan & Benefits**.

Choose 2018 Standard Commercial Formulary to view your drug list.

If you would like a hard copy of the drug list, call us at **800-826-0940** to request one.

What will my drugs cost?

What you pay for a prescription drug depends on what tier the drug is listed as in our drug list.

You can find out the cost of your drugs by signing in to My Account at networkhealth.com, calling CVS/caremark at 855-801-8184 or by doing the following.

- Find your drug name on our drug list.
- Look at which tier your drug is (1, 2, 3, 4, 5 or 6). This tier number determines what the fee will be. The higher the tier number, the more you will pay.
- To find what you pay for that tier, see the Prescription Coverage section of the Summary of Member Responsibility Table inside your Member Handbook.

Find a pharmacy

For your prescriptions to be covered, you'll need to make sure to use a pharmacy that's part of your plan. To find network pharmacies in your area, visit **networkhealth.com** and click **Find a Pharmacy** on the right. You can also search for pharmacies when signed in to My Account.

Your Member Reference Guide

Important Phone Numbers

Customer Service

- **800-826-0940** (plans through an employer)
- **855-275-1400** (plans for individuals and families)
- Network Health offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call **800-947-3529**.
- Bilingual language assistance or translation services are also available by calling **800-826-0940 or 855-275-1400**. Callers may leave a message 24 hours a day, seven days a week.
- Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **800-826-0940 o 855-275-1400.** Alguien que hable español le podrá ayudar.

Care Management

- **800-236-0208**

Behavioral Health

- **800-555-3616**

CVS/caremark™ Customer Service

- **855-282-8476** (plans through an employer)
- **855-801-8184** (plans for individuals and families)

Your Membership

The benefits of your coverage are outlined in your coverage document, which you received when you enrolled. Some plans have copayments, coinsurance or deductible requirements. Each plan's coverage varies. If your plan does require a copayment, you may be responsible for paying it at the time of service or be billed by the health care provider. If you have questions about your health care coverage, please check your coverage document, Summary of Member Responsibility Table or applicable Riders for benefits that apply to you, or call our customer service department at the phone number listed at the beginning of this member reference guide.

Network Health does not discriminate. If you need assistance in using any of our services, please contact our customer service department at the phone number listed at the beginning of this member reference guide.

Using My Account

To access our member portal, go to **networkhealth.com/MyAccount**. **(Note: Your member ID, found on your insurance card, is required for registration.)**

Once signed in you can:

- View benefit and plan information
- See the status of your claims and the history of past claims
- Order prescriptions and ask for them to be delivered to your home
- Compare prescription drug costs and find information about specific drugs
- Send a private email to our customer service department to ask questions
- Access the WebMD® Health Management Center, which offers the following.
  - Condition centers
  - Lifestyle improvement programs
  - Extensive health library with personal tools pertaining to health topics important to you
  - Health risk assessment
  - A place to record information about you and your family

Your Primary Care Physician

Your personal doctor is called your primary care physician (PCP). It's important you pick one doctor to coordinate all your care. Because this doctor will become familiar with you, he or she can help make sure you get the care you need, and can make it easier to keep tabs on your overall health. Your doctor can also recommend the best treatment for you, if you need care from other providers.

Selecting a primary care physician (PCP) is very important. If you have not selected a PCP, Network Health will assign you one. If you'd like to designate a PCP, please share this information with Network Health customer service by calling the number on your ID card. If you haven't or don't wish to designate a PCP, Network Health will rely on claims data to assign you a PCP. Our system automatically assigns PCPs to members based on primary care doctors you've seen the most who are part of your plan and accepting new patients. For those who haven't seen a PCP in two years, Network Health will work with our provider partners to assign you a PCP who is in your area and accepting new patients. Whether your PCP is selected or assigned, you'll receive the same high quality care you've come to expect, and we will communicate with your PCP to help coordinate your care.*

It's important that you and/or each member of your family have one main PCP. Also, family members don't have to have the same PCP, and you can change your PCP at any time you'd like by calling customer service.

You can also search doctors and specific facilities at any time by going to **networkhealth.com** and clicking on the **Find a Doctor** or **Find a Facility** button.

It's important to note to receive full coverage when seeing a provider that he or she must be providing the services at a contracted location.

** Excludes self-funded groups with plans administered by Network Health Administrative Services.*

Emergencies

When you or a family member faces a medical emergency, you don't want to worry about your health care coverage.

When an emergency occurs, go to the nearest emergency facility. Call 911 if the service is available in your area. During an emergent situation, Network Health will cover the cost of your medical care, excluding any applicable copayment, whether you are at a facility Network Health is contracted with or not.
An emergency can be defined as when you experience an injury, a worsening medical condition or illness, or severe pain, and you or others feel that your health is in serious danger if you do not receive help immediately.
If you or a family member is unsure if your condition is an emergency or may require care after regular office hours, call your doctor's office. You may also call the Network Health Nurse Line at **888-879-8960**. Your doctor, the on-call doctor or the Network Health Nurse Line will be able to assist you.

Urgent Care Services

During regular office hours, please call your doctor. The time of day hospital urgent care services are available varies depending on the facility.

You may receive urgent care services from a hospital-based or non-hospital-based urgent care facility.

If you receive urgent care services from a non-participating urgent care facility, you will receive

the in-network cost only if one of the following is true.

- You receive the services in the emergency department of a hospital or in a hospital-based urgent care facility
- You receive the services in a non-hospital-based urgent care facility and you provide us with notification within 48 hours of receiving the service.

Please call our care management department at the phone number listed at the beginning of this member reference guide if providing notification. For mental health and substance abuse services call our care management behavioral health department at the phone number listed at the beginning of this member reference guide.

Customer Service

If you have any questions about our provider network, benefits, how to submit a claim or specific services, please call our customer service department at the phone number listed at the beginning of this member reference guide. We are available from 8 a.m. to 5 p.m. on Monday, Wednesday, Thursday and Friday, and 8 a.m. to 4 p.m. on Tuesday. Our customer service department also offers bilingual language assistance or translation services.

If you are dissatisfied with a health care provider or a service you received, call us to help resolve the issue.

You can also learn about filing a grievance or appeal at **networkhealth.com/members** and selecting the **Resources** tab on the right side of the page. Then click **Learn More** button.

How to Access Care When Outside of the Network Health Service Area

If you cannot safely travel to receive care from your primary care practitioner (PCP) you should do the following when seeking emergent medical care outside of the Network Health coverage area.

- Seek help at an emergency room
- Seek help at a hospital-based urgent care facility
- Seek help at the college's medical center (for dependents away at college)
- Present your member ID card when admitted to a hospital emergency room
- Notify Network Health within 48 hours if you are admitted to the hospital for continued observation or as an inpatient

Your PCP must provide follow-up care. If this is not possible, follow-up care must be coordinated by your PCP and authorized by Network Health.

Consult your coverage document. You may be responsible for copayments. Some out-of-area medical facilities may require payment for care at the time it is given. Learn how to request reimbursement in the next section.

Submitting a Claim

Most hospitals and doctor offices will submit claims on your behalf. But some out-of-area medical facilities may require that you pay for care at the time it's given.

To arrange for reimbursement, you must send itemized bills and proof of payment within 90 days to Network Health. You can send these to Attn: Claims Department, P.O. Box 568, Menasha, WI 54952. For more information, contact our customer service department at the phone number listed at the beginning of this member reference guide.

Prescription Drug Benefits

The CVS/caremark customer service center is open 24 hours a day, seven days a week to answer questions by calling the phone number listed at the beginning of this member reference guide.

To find more prescription benefit information or to access the Preferred Drug List, visit **networkhealth.com/members**. Select the **Drug Coverage** tab on the right side of the page and click on the **Learn More** button. Here you will learn about drugs that require authorization, have step therapy requirements, quantity level limits and much more.

You can also search for pharmacies by visiting **networkhealth.com** and clicking on the **Find a Facilities** button.

Network Health Nurse Line

For answers to general health and wellness questions or for help selecting a doctor, please call the Network Health Nurse Line at **888-879-8960 (TTY 888-833-4271)**. It's available 24 hours a day, seven days a week and provides support from a personal health coach. Health coaches are nurses who provide information specific to your health questions. Their goal is to help you get all of the information you need to make the right decision for you. The Network Health Nurse Line is a no-cost resource to help you manage your health.

Health Management

Whether you have a serious health problem, or just want to get in shape, Network Health offers the tools you need to be your best. We provide case management and condition management services as well as information about self-management workshops offered throughout Wisconsin.

Case Management
Network Health provides case management services for individuals who suffer from a chronic condition, have an illness that could lead to a high-risk condition or have a need for increased use of health care services.

Individuals who may benefit from case management services include those who have the following conditions.

- Chronic disease (heart failure, cancer, end-stage renal disease, diabetes)
- Catastrophic condition (heart attack, stroke, premature infancy, high-risk pregnancy, trauma, spinal cord injury and individuals scheduled or soon-to-be scheduled for a transplant)
- Other complicated and/or high-risk conditions identified by the case management staff.

For more information about case management or to request help with a health condition visit **networkhealth.com** and select the **Health & Wellness** tab. Scroll down and click the **Learn More** button under the **One-on-One Support**.

Condition Management
Condition management programs can help empower you to take charge of your health and better manage your health condition. We have programs available for the following conditions.

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Heart disease or stroke
- Heart failure

For more details, visit **networkhealth.com** and select the **Health & Wellness** tab. Scroll down

and click the **Learn More** button under the **Condition Management**.

Self-Management Workshops
The following workshops are offered throughout Wisconsin and can teach you how to best manage the most common symptoms of your condition.

- Living Well with Chronic Conditions
- Healthy Living with Diabetes
- Stepping On

For more details about these workshops visit **networkhealth.com** and select the **Health & Wellness** tab. Scroll down and select the workshop of your choice.

Additional Resources

Additional resources are available for members. You can find information on all the topics below by visiting **networkhealth.com/members** and selecting the **Resources** tab on the right side of the page. Then click **Learn More** button.

- **Confidentiality** – We make sure your health information remains protected and confidential.
- **Inpatient Hospital Care** – Prior authorization information for hospital observation or inpatient stays.
- **New Technologies** – Learn about how we evaluate new medical technologies on a regular basis.
- **Privacy Practices** – See how we protect our members' privacy.
- **Referrals and Authorization** – Information on getting specialty care and approvals for certain services.
- **Right to Request an Independent Review** – Have an Independent Review Organization (IRO) review certain decisions for care made by Network Health.
- **Utilization Decisions** – Read more about how makes utilization decisions based on appropriateness of care and service.

If you would like a hard copy of any of the items listed above, please call our customer service department at the phone number listed at the beginning of this member reference guide.

Updated November 2017

network health

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you are experiencing problems with Network Health, please contact us at the address or phone number below. If you are experiencing problems with your insurance agent, please contact them directly to resolve the issue.

Network Health
1570 Midway Place
Menasha WI 54952
800-826-0940

You can also file a written complaint with the Office of the Commissioner of Insurance (OCI) and send it to the address below. The OCI is a state agency which enforces Wisconsin's insurance laws.

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison WI 53707-7873

To request a hard copy complaint form, call 800-236-8517. You can also file a complaint online at **www.oci.wi.gov**.

NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Network Health Plan (NHP) and Network Health Insurance Corporation (NHIC) are committed to protecting the privacy of your confidential health information. This includes all oral, written and electronic protected health information across our organization. This Notice of Privacy Practices will be followed by all associates of our workforce, regardless of geographical location. It describes how medical and financial information about you may be used and disclosed and how you can get access to or limit sharing of this information. Please review it carefully.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health and non-public personal information.
- We must follow either Federal or State law, whichever is more protective of your privacy rights.
- We will let you know promptly if a breach occurs which may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html and https://www.ftc.gov/tips-advice/business-center/privacy-and-security/gramm-leach-bliley-act

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide you with a copy or summary of your health and claims records within 30 days of your request. We may charge a reasonable, cost-based fee.
- If we need an extension, we will let you know in writing the reason and a date when we will provide the records.
- We may say “no” to your request, but we’ll tell you why in writing within 30 days with additional information on how you can have the decision reviewed.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days and include information on how you can appeal this decision.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what health information we use or share

- You can ask us not to use or share certain health information. Your request must be made in writing.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared health information

- You can ask for a list showing the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one list per year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also print a copy at any time from our website, networkhealth.com.

Choose someone to act for you
- If you have given someone durable power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting the Privacy Manager, at 800-826-0940. Complaints may also be made in writing to

  Network Health
  Attn: Compliance
  1570 Midway Pl.
  Menasha, WI 54952

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Use or share information related to psychotherapy notes, substance abuse, developmental disability, alcohol and other drug abuse (AODA) and HIV testing
- Marketing purposes, except for health-related benefits and services (see Health-Related Benefits and Services below)
- Sale of your information
- Research
- Fundraising purposes
- Any other uses and disclosures not described in this notice

OUR USES AND DISCLOSURES
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
For example - A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
We can use and disclose your information to run our organization and contact you when necessary.
For example - We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
For example - We may need to disclose your health information with our contracted pharmacy benefit manager to coordinate payment for any prescriptions you may need.

Administer your plan
We can disclose your health information to a third party claims payor for enrollment and claims processing.
For example - We contract with a third party vendor to conduct enrollment and claims processing functions. Therefore, we may disclose your health information to conduct necessary functions to process your enrollment and health care claims.

Business Associates
We may disclose your health information to persons or organizations which perform a service for us that requires the use or sharing of health information. Such persons or organizations are our contracted business associates, and they are held to the same privacy standards as our organization.
For example – We may need to disclose your health information to a mailing and fulfillment vendor for them to print and mail a letter to you about our diabetes program.

Health-Related Products, Benefits and Services
We may contact you to give you information about certain health-related benefits and services which may be of interest to you. We may also contact you to recommend alternative treatments, health care providers or care settings.
For example – If we think you could benefit from an annual health assessment in your home, we may send you a letter with information about it.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?
We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information about this visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing or controlling disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Notification and communication with family and friends
We may share health information about you with family members, friends or others you identify as being involved in your health care or payment for your health care. We will disclose only the health information relevant to the person's involvement. If you are unable or unavailable to agree or object to a disclosure to such a person, we will use our best professional judgment in communicating with your family or friends.

Compliance with the law
We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if they want to see that we're complying with federal privacy law.

Your Employer or Organization Sponsoring Your Health (pertains to group health plans only)
We may disclose to your employer whether you are enrolled in or have disenrolled from a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan.

We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document to see whether your employer may receive this information and for a full explanation of those limitations.

Respond to organ, eye and tissue donation and transplantation requests and work with a medical examiner or funeral director
- We can share health information about you with organ, eye and tissue procurement and transplantation organizations.
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests
We can use or share health information about you for the following.
- Workers' compensation claims
- Law enforcement purposes or with a law enforcement official

- Health oversight agencies for activities authorized by law, such as audits and investigations related to the oversight of government benefit programs (like Medicare)
- Special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Disaster relief
We may use or disclose your name and location to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

CHANGES TO THE TERMS OF THIS NOTICE

This notice takes effect July 1, 2017, and it will remain in effect until we replace it. We can change the terms of this notice, and the changes will apply to all information we have about you. Any changes to the notice will be effective for all of your records created or maintained in the past, as well as any records we create or maintain in the future. The new notice will be available upon request, on our website, and we will mail a copy to you. If there are no changes to the notice, you will be notified at least every three years that this notice is available to you.

FINANCIAL INFORMATION PRIVACY

Network Health Plan and Network Health Insurance Corporation are committed to maintaining the confidentiality of your personal financial information. We collect personal and financial information about you to perform functions such as premium payment transactions and electronic funds transfers.

We do not disclose personal financial information about past, present or future members to any third party, except as required or permitted by law. Access to your personal financial information is restricted only to employees, affiliates and service providers who are involved in administering 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 and financial information to financial institutions which perform services for us, such as electronic fund transfer for payment of premiums.

We may begin disclosing this information as soon as you submit an application to become a member of Network Health. Once you're no longer a member, we may continue to share this information as described in this notice.

In limited circumstances, you can ask us to limit sharing of this information by calling customer service at 800-826-0940, or submitting a written request to:

Network Health
Attn: Compliance
1570 Midway Pl.
Menasha, WI 54952

OTHER INSTRUCTIONS FOR NOTICE

If you have questions about any part of this notice or would like to request a copy, you may call the customer service department at 800-826-0940, Monday – Friday, 8 a.m. – 5 p.m. TTY users may call 800-947-3529.

Patient Protection

Network Health generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. To obtain information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Network Health Customer Service at 920-720-1300 or 800-826-0940.

You do not need prior authorization from Network Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Network Health Customer Service at 920-720-1300 or 800-826-0940.

Network Health
1570 Midway Pl.
Menasha, WI 54952