WINhealth PARTNERS

Freedom 1500

Individual Health Benefits Plan

This Healthplan includes comprehensive wellness benefits as defined in Wyoming Statute 26-18-103(b). For more information about the comprehensive adult wellness benefits see page 11.

WINHEALTH PARTNERS HEALTHPLAN BENEFIT SUMMARY
FREEDOM 1500

Deductible *(Waived for Physician Office Visits and Preventive Services)*	**$**1500 Single/$4500 Family

PROFESSIONAL SERVICES/PHYSICIAN	**YOUR COST**
Office Visit *(Waived for Preventive Services)*	$30
Prenatal Service Package ♦ *(Covered up to $1000 at time of delivery)*	
Allergy Injection Visit	$30
Urgent Care Visit	$30
Home Health Care Visit ♦	$0
Hospice ♦	$0
Behavioral Health Visit *(Not a covered benefit)*	100%
Chiropractic Visit *(Not a covered benefit)*	100%

FACILITY SERVICES	**YOUR COST**
Inpatient/Observation Hospital – Medical ♦	20%
Inpatient Hospital – Behavioral Health *(Not a covered benefit)*	100%
Outpatient Surgery/Office Surgery	20%
Emergency Room/Treatment Room	$150
Ambulance *($10,000 per Trip Benefit)*	$150
Skilled Nursing Facility ♦ *(100 Days Lifetime Maximum)*	$0

DIAGNOSTIC AND THERAPEUTIC SERVICES	**YOUR COST**
Laboratory Testing	$0
Radiology	$0
Diagnostic Studies ♦ *(E.g. MRI, CT, Diagnostic Scans)*	20%
Physical Therapy ♦ *($2,500 Benefit)*	$30
Speech Therapy ♦ *($2,500 Benefit)*	$30
Occupational Therapy ♦ *($2,500 Benefit)*	$30
Cardiac Rehabilitation ♦ *($2,500 Benefit)*	$30
Durable Medical Equipment ♦ *($5,000 Benefit)*	20%
Injectable Medication ♦ *(Growth hormones only. All injectables require prior authorization)*	20%

PHARMACY SERVICES *(Copayments for mail order pharmacy are twice the listed amount for a ninety (90) day supply)*	**YOUR COST**
Deductible	$50
Coinsurance	0%
Generic Prescriptions	$10
Preferred Brand Prescriptions	$15
Non-preferred Brand Prescriptions	$40
Discounted Brand Prescriptions	100%

♦Requires Physician Referral and/or Preauthorization by WINhealth Partners
Medical Annual Out of Pocket Maximum: $5,000 Single/$10,000 Family *(Excludes Rx)*

Benefits are available for services provided by participating providers only, except in urgent or emergent situations, or when referred by a participating physician and approved by WINhealth Partners.

Drugs listed as "preventive" in the evidence of coverage are not subject to any medical or prescription deductible and/or copay when prescribed according to preventive guidelines.

This is not to be considered full disclosure of the benefit plan. Please read the information provided in the remainder of this book for full benefit details including exclusions, limits and preauthorization requirements.
Revised July 15, 2010

COVERED SERVICES

All benefits are subject to plan limitations and Exclusions as defined in Section 6(II). Services that are not specifically identified in this Section are not a covered benefit.

I. DESCRIPTION OF PLAN BENEFITS

1. AMBULANCE

Covered

Ambulance for Emergency transport to the nearest Hospital or medical facility that is equipped to furnish the services is covered when medically indicated. Ambulance transport when used for patient or family convenience is not a covered benefit. A Copayment applies for both air and ground transport.

Air Ambulance - Benefits are payable when ground transportation is not available or feasible, or if the Member's medical Condition warrants transport by air ambulance.

Alternate Transportation - Benefits are not payable for transportation other than by a ground or air ambulance that is specially designed and licensed for transporting patients, and is operated by trained personnel.

Limits

A per trip benefit maximum applies for both air and ground transport.

Not Covered

Ambulance service provided due to the absence of another form of transportation or solely for the Member's convenience is not covered.

2. ANESTHESIA

Covered

The provision of anesthesia during surgical procedures is a Covered Service when necessary for a covered surgical procedure and when provided by a Participating Physician or Participating Certified Registered Nurse Anesthetist (CRNA).

When surgery is performed during a Hospital Confinement, anesthesia services will only be covered when WINhealth Partners has Preauthorized the Hospital Confinement. All elective surgical procedures require the use of a WINhealth Partners network Participating Provider in order to be a Covered Service.

Limits

Anesthesia services provided at the time of a non-covered procedure are not a Covered Service.

3. CARDIAC REHABILITATION

Covered

Cardiac Rehabilitation benefits are available to Members following acute cardiac diagnoses and treatment, as long as the rehabilitation takes place no earlier than two (2) months prior to or no later than eight (8) months after the triggering cardiac event. Cardiac Rehabilitation services must be Preauthorized.

Limits

Benefits for cardiac rehabilitation services are covered on an outpatient basis up to the maximum per incident, subject to the applicable Copayment or Coinsurance.

4. CHEMOTHERAPY

Covered

- Outpatient injectable chemotherapy, when oral administration of prescribed medication is not medically appropriate
- Services and materials for chemotherapy

5. DENTAL SERVICES

Covered

Coverage is available for the following dental services only:

- Treatment for an accidental injury to the mouth, teeth, or jaw; in which the initial service is performed within ninety (90) days of the accident, and in which treatment is completed within twelve (12) months of the accident. The accidental Injury cannot be a result of biting or chewing. Treatment must be for restorative services and supplies necessary to promptly repair but not replace sound natural teeth.
- Incision and drainage of a cyst or cellulitis that does not originate in the teeth
- Surgical removal of tumors and cysts
- All dental services must be Preauthorized

Limits

- Restoration of the mouth, teeth, or jaw due to an accidental Injury is limited to those that are Medically Necessary.
- Facility charges for hospitalization at a Participating Hospital for dental procedures are covered only when a non-dental medical condition exists that makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure unless it is described as a Covered Service in this Section 6, and has been Preauthorized.

Not Covered

- Services provided for the treatment of conditions or complications related to teeth, including tooth abscess are not Covered Services unless the complication is life-threatening.
- Coverage is not available for cosmetic replacement of serviceable restorations, materials that are more expensive than necessary for restoration of damaged teeth, and personalized restorations.
- Coverage is not available for Physician or Dentist services related to dental care except as noted in limits above.
- Shortening of the mandible or maxilla for cosmetic purposes
- Hospitalization, including anesthesia, for extraction of teeth
- All dental services or supplies for preventive treatment of disease of the teeth, alveolar processes, supportive tissues (gums), and dental x-rays

6. DIABETES CARE

Covered

Coverage under this policy includes benefits for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-

insulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. Such services must be Preauthorized by WINhealth Partners.

Limits

Self-management training and education shall be limited to:

- A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis.
- Additional medically necessary self-management training shall be provided upon a significant change in symptoms, Condition or treatment. This additional training shall be limited to three (3) hours.
- Benefits for self-management training will be subject to the same Copayments and Deductibles applicable for other Covered Services under this policy.
- All services must be Preauthorized.

7. EMERGENCY CARE WITHIN SERVICE AREA

Covered

A medical Emergency is the sudden and unexpected onset of a Condition or an Injury that you believe endangers your life or could result in serious Injury or disability, and requires immediate medical or surgical care. It is a condition where a prudent layperson, acting reasonably, would believe that emergency medical care is necessary. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute Conditions that are medical emergencies – what they all have in common is the need for quick action. Whenever Emergency Healthcare Services are obtained, a Participating Physician must provide all follow-up care unless Healthcare Services by a Non-Participating Provider are Preauthorized by WINhealth Partners.

If the Member does not comply with the following rules and the applicable rules stated in Section 5, Emergency Healthcare Services may not be Covered Services under the Health Plan:

- Obtaining Emergency Healthcare Services - In a life- or limb-threatening Emergency, a Member should call 911 or go directly to the nearest Hospital emergency room or medical facility for treatment.
- Transfer to Participating Hospital - If a Member is in Confinement in a Hospital that is a Non-Participating Provider, WINhealth Partners, may elect to transfer the Member to a facility that is a Participating Provider, if the Member's attending Physician approves the transfer as medically appropriate. If the Member refuses a medically appropriate transfer to a Participating Hospital, any additional Healthcare Services or supplies provided by Non-Participating Providers with respect to the Member's Condition will not be Covered Services.
- Healthcare Services Are Not Emergency Healthcare Services- When services or supplies are not indicated as a medical emergency based on generally accepted medical criteria then such Healthcare Services or supplies will not be Covered Services.

Limits

- Emergency Healthcare Services do not require Preauthorization. However, non-emergent Healthcare Services obtained in an emergency room are not Covered Services.
- If a Member is admitted to the Hospital, the emergency room Copayment is waived.
- WINhealth Partners may review use of emergency facilities. Payments of claims may be denied and may be Member's personal responsibility.
- In a life- or limb-threatening Emergency the Member should call 911 or the local equivalent.
- If the Member is hospitalized at a Non-Participating facility, WINhealth Partners may elect to transfer the Member to a Participating Hospital as soon as it is medically appropriate. WINhealth Partners will pay for such transfer. If, after the attending Physician has approved transfer, the Member chooses to remain in the Non-Participating facility, further services will not be Covered Services.

Not Covered

- Non-emergent services and services that are found to not be Medically Necessary
- Follow-up care in the emergency facility
- Follow-up care provided by Non-Participating Providers
- Emergency Healthcare Services do not require Preauthorization. Therefore, the Member must be responsible for using emergency facilities appropriately. Non-Emergency Healthcare Services are not Covered Services when rendered in an emergency facility.

8. EMERGENCY CARE OUTSIDE SERVICE AREA

Covered

- If a Member receives Emergency Healthcare Services outside the WINhealth Partners' Service Area, Reimbursable Services will include: Reasonable and Customary Charges for Hospital services that are emergent Covered Services;
- Reasonable and Customary Charges for professional services that are Covered Services;
- Reasonable and Customary Charges for transportation authorized by WINhealth Partners to return the Member to a Participating Hospital, less the cost of Member's normal return trip expense.

Limits

- WINhealth Partners must Preauthorize Hospital admissions (except for admissions for labor and delivery) including those that occur outside the Service Area. Claims for Reimbursable Services must be submitted to WINhealth Partners within one-hundred-twenty (120) days after the date of the Healthcare Service.

9. GENETIC TESTING / GENETIC COUNSELING

Not Covered

All testing for genetic information

10. HEMODIALYSIS

Covered

All necessary services for hemodialysis for chronic renal disease and for kidney transplants including training

11. HOME HEALTHCARE

Covered

Home healthcare expenses are Covered Services when a Member is homebound if such services are considered Medically Necessary and ordered by a Participating Physician and Preauthorized by WINhealth Partners.

Limits

- For expenses to be covered, the Physician must provide a treatment program that includes specifications for the estimated time that home care is needed and which services are needed.
- Benefit is limited to sixty (60) visits per incident per plan year.
- Physician must periodically review the progress, and, as necessary, change or alter the treatment program. Expenses for home healthcare are Covered Services as long as the patient continues to benefit from the care, subject to the sixty (60) visits per incident per plan year limitation.

Not Covered

Home health services that are not Covered Services include, but are not limited to the following:

- Care by a nurse's aide, family member or person residing with the Member
- Laundry services
- Housecleaning services
- Home companion
- Assisted daily living services
- Custodial care
- Private duty nursing
- Disposable supplies
- Transportation

12. HOSPICE

Covered

Hospice care is covered when the member is in the final stages of a terminal Illness or life-limiting condition. The care is usually administered by a team of professionals and volunteers that typically include a Physician, registered nurse, social worker, member of the clergy, and a psychologist.

Limits

Benefits will apply when services are provided under the direction of the Member's Personal Care Physician, who certifies that the member is in the final stages of a terminal Illness or life-limiting condition.

Hospice care is for terminal conditions and is based upon the concept that those Members receiving hospice care choose only palliative care and symptom management rather than other Healthcare Services aimed at aggressive treatment or a medical cure for the terminal condition. While receiving hospice care in the Member's home or in a hospice facility, if a Member requires treatment for a condition not related to the terminal Illness, WINhealth Partners will cover Healthcare Services for those Covered Services.

Not Covered

- Voluntary services or supplies

- Counseling by clergy or voluntary groups
- Services performed after the death of the patient
- Services and supplies related to the terminal condition that are not a part of Hospice Care
- Services of a caregiver other than provided by the hospice agency, including but not limited to, someone who lives in the Member's home or someone who is a relative of the member
- Services that provide a protective environment where no professional skill is required, such as companionship or sitter services
- Services not related to the medical care of the Member, including but not limited to legal services, estate planning, funeral costs, food services such as Meals on Wheels, transportation services except covered Medically Necessary professional ambulance services

13. HOSPITAL CARE

Covered

Inpatient Hospital services for medical conditions are Covered Services if the Confinement has been Preauthorized and the services are Covered Services.

- Room and board expenses including the cost of a semi-private room, meal services for the patient, nursing services, and laundry services
- Ancillary Services - Services which are rendered during an inpatient stay include drugs and pharmaceuticals, medical supplies, blood administration, diagnostic and therapeutic services
- Coordinated discharge planning services
- Private room when Preauthorized by WINhealth Partners
- Emergency Confinement requires notification to WINhealth Partners within two (2) business days.

Not Covered

- Prescription drugs issued by the Hospital for use after Confinement ends
- Private duty nursing
- Convenience items: Those services and supplies provided for personal convenience which are not medically indicated, such as grooming items, guest meals, television, telephone expenses, etc.

14. LABORATORY SERVICES

Covered

- Medically Necessary laboratory services are Covered Services when requested by a Participating Physician and rendered by a Participating Provider.
- STD screening for documented cases of sexual assault reported to police

Not Covered

- Laboratory tests that are not related to a specific Illness or Injury are not Covered Services unless provided according to the schedule of preventive services.
- Laboratory services ordered by a non-Participating Physician or performed by a Non-Participating Provider
- Genetic Testing

15. MATERNITY CARE

Not Covered

All maternity services are not Covered Services under this Health Plan.

16. MENTAL HEALTH AND SUBSTANCE ABUSE

Not Covered

All Mental Health and Substance Abuse services are not Covered Services under this Health Plan.

17. PHYSICIAN SERVICES

Covered

- Physician services including time for visits and examinations, consultation, and personal attendance with the Member in the Physician's office, Hospital, or Skilled Nursing Facility
- Physician's visits to the Member's home when Medically Necessary and only if the Member is too ill or disabled to go to the Physician's office
- Medical consultation services, including charges made by a Physician for a second opinion

Not Covered

- Examination for employment, licensing, insurance, adoption purposes, or court-ordered examination or treatment, travel, school, or sports
- Expenses for medical reports, including preparation and presentation
- Expenses for examinations and treatment conducted for the purpose of medical research
- Expenses related to missed appointments and rescheduling fees
- Expenses for Physician waiting or standby time, after hours services, and other additional charges

18. PODIATRIC CARE

Covered

Services rendered by a Podiatrist are covered when referred by a Participating Physician and Preauthorized by WINhealth Partners.

Limits

All podiatry services must be referred by a Participating Physician to a Participating Podiatrist. Services must be Preauthorized.

Not Covered

Benefits do not include Coverage for orthotic devices, strapping, ultrasound, or the treatment of weak, strained or flat feet. The cutting, removal, or treatment of corns, calluses or trimming the free edge of toenails, in the absence of active treatment of a metabolic or peripheral vascular disease is not covered.

20. PRENATAL CARE

Covered

- Prenatal Care billed at time of delivery.
- Covered with a maximum benefit of $1000 per delivery.

Limits

- Member must be eligible for coverage at time of delivery.

20. PRESCRIPTION DRUGS

Benefits for prescription drugs are determined using the Preferred Drug List. All generic drugs are subject to the lowest copayment. Brand name drugs that are listed on the Preferred Drug List are subject to the second level copayment. However, when a generic equivalent becomes available for a covered brand name drug, the generic drug will be subject to the lowest Copayment and the brand name prescription drug will be subject to the highest Copayment. Covered brand name prescription drugs that are not listed on the Preferred Drug List are subject to the highest Copayment.

Covered

A description of your prescription drug Coverage can be found in your Schedule of Benefits. To fill a prescription, present the written prescription to a participating pharmacy along with your prescription drug card.

Preferred Drugs - Generic and brand name prescription drugs that are included on the WINhealth Partners' Preferred Drug List are covered at the lower Copayment or Coinsurance level.

Non-Preferred Drugs - Brand name drugs that are not listed on the WINhealth Partners' Preferred Drug List are subject to a higher "non-preferred" Copayment or Coinsurance amount.

Diabetic Supplies - Diabetic supplies (test strips, alcohol swabs, lancets, and syringes) are covered items for Members with a diagnosis of diabetes. To receive this benefit, present a prescription from a Participating Provider to one of the WINhealth Partners' participating pharmacies.

Limits

- After meeting any applicable annual Deductible, Copayment and/or Coinsurance, a thirty-four (34) day supply of the covered drug may be dispensed from a participating retail pharmacy.
- For maintenance drugs, as defined by standard lists, a ninety (90) day supply may be dispensed if applicable Copayments and/or Coinsurance are paid.
- Prescriptions are covered with varying Copayments for brand and generic medications. If a brand drug is listed in the Preferred Drug List and is dispensed, a brand Copayment is required even if the medication being ordered has no generic equivalent. This is the 2nd or middle tier Copayment. If a brand name medication is dispensed when the generic equivalent is available, the Member will be responsible for the brand Copayment plus the difference in price between the generic and brand medications.
- A maximum quantity for a maintenance prescription drug purchased through either the mail service or retail cannot exceed a ninety (90) day supply.
- Some prescription drugs need Preauthorization before benefits will be available. A drug is authorized for the length of treatment not to exceed a one (1) year period of time. Examples of drugs needing Preauthorization by WINhealth Partners include:
  - Injectable medications
  - Impotency agents
  - Interferon/Intron/Avonex
  - Growth hormones

- Accutane
- Retin A or equivalent for adult acne
- Drugs exceeding $500 per month
- Other drugs, not listed here, may be added to those requiring Preauthorization. Call WINhealth Partners if any question as to whether a drug requires Preauthorization.

Not Covered

Excluded Drugs: Not all prescription medications are covered. Members can contact the WINhealth Partners' Medical Management department with questions about Coverage for the specific medication prescribed. Some examples of drugs excluded from Coverage are*:*

- Weight-loss drugs
- Smoking cessation drugs
- Medications that are available without a prescription except for the following preventative indications when accompanied by a Physician's prescription:
  - Low dose aspirin for prevention of heart disease in men age 45-79
  - Low dose aspirin for prevention of ischemic strokes in women age 55-79
  - Folic acid for reproductive age women (age 18-44)
- Experimental or investigational drugs
- Drugs for cosmetic purposes
- Drugs for conditions that are excluded from Coverage

21. PREVENTIVE SERVICES

Covered

The list of preventive services covers a full range of immunizations and diagnostic tests and screenings for members of all ages. The services below are recommended by the following agencies: Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the State of Wyoming. There will be no member cost sharing for the preventative services listed below as long as the services are provided by a Participating Physician and are offered in accordance with the following schedule. However, if at any point any of the below preventative services cease to be a recommended preventative service, Copayment's and Deductible's may apply.

Schedule of Preventive Benefits

Under One Year of Age

- Two (2) normal newborn care exams prior to Hospital discharge
- One-time newborn test for hearing loss
- Six (6) well-child examinations*
- One (1) newborn genetic screen as recommended by the Wyoming Department of Health
- Immunizations per American Academy of Pediatrics and Centers for Disease Control and Prevention Guidelines

One Year But Less Than Six Years

- Three (3) well-child exams* between ages 1-2 years
- Annual well-child examination* between the ages 2-6 (but no more than one (1) exam in any (twelve) 12 continuous months)

- Immunizations as per American Academy of Pediatrics and Centers for Disease Control and Prevention Guidelines
- Annual hematocrit/hemoglobin
- One (1) eye examination between 3-6 yrs. by an ophthalmologist
- Hearing screening and testing as recommended by a participating healthcare provider

Six Years But Less Than Twelve Years

- Well-child examinations* (One (1) examination every two (2) years)
- One (1) routine eye examination every two (2) years, maximum benefit per examination of $60.00
- One (1) tuberculosis skin test
- One (1) dipstick urine per well-child examination
- One (1) hematocrit/hemoglobin per well-child examination
- One (1) immunization for measles, mumps, rubella, if not done previously between ages 4-6
- Immunizations per American Academy of Pediatrics and Centers for Disease Control and Prevention Guidelines
- Hearing screening and testing as recommended by a participating healthcare provider

Twelve Years and Older

- Annual Screening for the following sexually transmitted diseases as deemed appropriate by recommended guidelines and your healthcare provider:
    - Gonorrhea
    - Chlamydia
- High risk patients only:
    - HIV
    - Syphilis

Twelve Years But Less than Eighteen Years

- Health maintenance visits* (One (1) examination every two (2) years)
- One (1) routine eye examination every two (2) years, maximum benefit per exam of $60.00
- Diphtheria/tetanus booster, if ten (10) years from previous booster
- Tuberculosis skin test
- Dipstick urine
- Hepatitis B vaccine series
- Pelvic examination, pap smear, and reflex HPV testing for sexually active females annually
- Immunizations per the Centers for Disease Control and Prevention Guidelines
- Hearing screening and testing as recommended by a participating healthcare provider (ages 12-16)

Eighteen Years But Less Than Forty

Men:

- Prostate examination for cancer, annually
- Health maintenance visit* every five (5) years
- Dipstick urine every five (5) years
- Complete blood count (CBC) every five (5) years
- Basic metabolic panel lab test every five (5) years

- Lipid screening every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually
- Immunizations per the Centers for Disease Control and Prevention Guidelines

Women:

- Pelvic examination, Pap smear, and reflex HPV testing, annually
- Clinical breast examination, annually
- Health maintenance visit* every five (5) years
- Dipstick urine every five (5) years
- Complete blood count (CBC) every five (5) years
- Lipid screening every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually
- Basic metabolic panel lab tests every five (5) years
- Immunizations per the Centers for Disease Control and Prevention Guidelines

- **High Risk Patients Only:**
  - EKG every five (5) years
  - Pneumococcal vaccine
  - Influenza vaccine annually
  - Hepatitis B vaccine
  - Diabetes screening with either fasting glucose and 2-hour postprandial glucose, or, glucose tolerance test every five (5) years

Forty Years But Less Than Sixty-five

Men:

- Prostate examination and laboratory tests for cancer, annually
- Health maintenance visit* every three (3) years
- Dipstick urine every three (3) years
- Complete blood count (CBC) every three (3) years
- Lipid screen every three (3) years
- Basic metabolic panel lab tests every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually
- Immunizations per the Centers for Disease Control and Prevention Guidelines

Women:

- Pelvic examination, pap smear, and reflex HPV testing, annually
- Clinical breast examination, annually
- Screening mammogram, annually
- Health maintenance visit* every three (3) years
- Dipstick urine every three (3) years
- Complete blood count (CBC) every three (3) years
- Lipid screen every three (3) years
- Basic metabolic panel lab tests every five (5) years
- Colorectal cancer examination and laboratory tests for cancer, annually
- Immunizations per the Centers for Disease Control and Prevention guidelines

- **High Risk Patients Only:**
  - EKG
  - tuberculosis skin test

- colonoscopy
- Diabetes screening with either fasting glucose and 2-hour postprandial glucose, or, glucose tolerance test every three (3) years
- Screening for osteoporosis by DEXA or FDA-approved ultrasonic exam every three (3) years after age 50 with identifiable risk factors for osteoporosis.

* Well-child examinations and health maintenance visits include but are not limited to physician counseling regarding diet, exercise, physician screening for obesity, depression, smoking cessation, alcohol misuse, sexually transmitted diseases, and blood pressure screening.

Limits
These recommendations are subject to change. All preventive services should be rendered upon the advice of a Participating Primary Care Physician.

22. RADIOLOGY SERVICES

Covered
Medically Necessary radiology services are covered when they are ordered by a Participating Physician and performed at a Participating facility.

Limits
The following procedures require Preauthorization and must be referred by a Participating Physician:
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET)
- Computerized Tomography (CT) Scans
- Radiology services ordered by a Non-Participating Physician or performed in a Non-Participating facility are not a Covered Service unless Preauthorized by WINhealth Partners.

Not Covered
ProstaScint

23. RECONSTRUCTIVE SURGERY

Covered
All stages of breast reconstruction surgery following a mastectomy when it is a Covered Service, such as:
- Surgery to produce a symmetrical appearance in the other breast after cancer surgery
- Treatment of any physical complications, such as lymphedemas
- One (1) Breast prosthesis every two (2) years and two (2) surgical bras per year

Not Covered
Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.
- Penile prosthesis (any type)
- Breast reduction surgery

24. SUPPLIES AND EQUIPMENT

Covered

Durable Medical Equipment (DME) - The purchase or rental of DME is covered when prescribed by a Participating Physician and Preauthorized by WINhealth Partners. Benefits paid for the rental of equipment will apply to the purchase price when applicable. The option to purchase versus rental of equipment will be determined based on the Member's length of need of the equipment.

Prostheses and Orthopedic Appliances - Devices used to support, eliminate, or restrict motion in a part of the body that is diseased or injured are Covered Services when Preauthorized by WINhealth Partners and medically indicated unless otherwise Excluded. The following prostheses and orthopedic appliances are covered:

- Artificial limbs
- Leg braces
- Arm and back braces

Medical Supplies - Including but not limited to:

- Colostomy bags and other supplies for their use
- Needles for administering insulin
- Oxygen services and supplies

Medical Equipment - Including but not limited to:

- Wheelchairs
- Crutches
- Infusion pumps (requires Preauthorization)

Limits

DME must be obtained from a Participating Provider and requires Preauthorization by WINhealth Partners.

Medically necessary durable medical supplies and equipment are subject to a Coinsurance per item and a maximum benefit per plan year for both rental and purchase of items. Repair of DME when properly maintained and verified by service records-requires Preauthorization.

Replacement costs will be Covered Services when the item is no longer repairable.

Not Covered

Some of the items not covered include:

- Convenience items
- Consumable supplies and equipment
- Deluxe items
- Maintenance of equipment
- Devices not medical in nature
- Customization of rental equipment
- Special braces or equipment
- Braces used as aids in sports and activities
- Corsets and other non-rigid appliances
- Prostheses for cosmetic purposes
- Repair, maintenance or replacement due to loss or for duplication
- Orthotic devices for podiatric use and arch support including wrapping
- Medical supplies used for comfort, convenience, personal hygiene or first aid (examples: support hose, bandages, adhesive tape, gauze, antiseptics)

- Surgical trays

25. SURGICAL ASSISTANTS

Covered

Some procedures may require the use of an assistant surgeon. Charges for assistant surgeon services are not Covered Services unless the surgery requires the use of an assistant surgeon in the majority of cases, and national guidelines indicate an assistant surgeon is appropriate.

Assistant surgeon services will be Covered Services when medically appropriate using Medicare guidelines, and when rendered by a qualified Participating Physician.

26. THERAPY, SPEECH

Covered

Speech therapy is covered when ordered by a Participating Physician and provided by a Participating speech therapy provider.

Limits

Coverage is only available when service is provided for treatment of head injury, stroke/CVA (Cerebral Vascular Accidents), or Injury to the structures and mechanism of phonation to restore previously existing speech and is subject to applicable Deductible, Copayment, and/or Coinsurance. Benefit is limited to the applicable benefit maximum per plan year.

27. THERAPY, OCCUPATIONAL

Covered

Occupational therapy is covered when ordered by a Participating Physician and provided by a Participating occupational therapy provider.

Limits

Occupational therapy benefit is limited to the applicable benefit maximum per incident per plan year and is subject to applicable Deductible, Copayment, and or Coinsurance. The benefit maximum per incident for occupational therapy is offered in combination with the benefit maximum per incident for physical therapy. An incident is medical procedure, an Illness, or an Injury where the therapy is being offered to regain previous level of function. Occupational therapy is only offered to regain a previous level of function after the Member has experienced an incident.

28. THERAPY, PHYSICAL

Covered

Physical therapy is a Covered Service when ordered by a Participating Physician and provided by a Participating physical therapy provider.

Limits

Benefit is limited to the applicable benefit maximum per incident per plan year and is subject to applicable Deductible, Copayment and/or Coinsurance. The benefit maximum per incident for physical therapy is offered in combination with the benefit maximum per incident for occupational therapy. An incident is medical procedure, an Illness, or an Injury where the therapy is being offered to regain previous level of function. Physical

therapy is only offered to regain a previous level of function after the Member has experienced an incident.

Not Covered

- Massage therapy
- Myofascial release therapy
- Paraffin bath

29. THERAPY, RADIATION

Covered

Services for radiation therapy when provided by a Participating Provider.

30. THERAPY AND REHABILITATION, GENERAL

Not Covered

Special evaluation and therapies including, but not limited to, the following are **not** Covered Services:

- Acupuncture
- Communication delay
- Learning disability
- Mental retardation and related Conditions
- Multiple handicaps
- Perceptual disorders
- Sensory deficit
- Sex addiction
- Vision therapy
- Behavioral training
- Biofeedback
- Coma stimulation
- Developmental and neuroeducational testing or treatment
- Educational services or studies
- Hearing therapies
- Hypnotherapy
- Myofunctional therapy
- Vocational rehabilitation
- Chelation therapy, except for heavy metal toxicity
- Maintenance Therapy

31. TRANSPLANTS

Covered

Human organ transplant services are Covered Services if not considered experimental or investigational, and when performed at a Designated Organ Transplant Facility. Services are covered based on criteria established by the medical community and WINhealth Partners and are provided only upon referral by the Member's Participating Physician. Covered Services include the directly related, reasonable medical and Hospital expenses of the donor and transportation if applicable.

Donor Expenses - Reasonable surgical costs directly related to the donation of the organ for a Member are covered if the organ transplant is covered.

Recipient Expenses - Recipient expenses directly related to the transplant procedure are covered, including pre-operative and post-operative care, surgical, storage, and

transportation costs directly related to the donation of an organ used in a covered organ transplant procedure.
Hospital Services - Hospital services directly related to the covered transplant procedure, including pre-operative and post-operative care.
Physician Services - Recipient medical expenses directly related to the covered transplant procedure, including pre-operative and post-operative care.
Transportation and Lodging - Transportation and lodging expenses for the patient and one (1) other individual accompanying the patient are covered up to a maximum of $5,000.

Limits

- All services related to a human organ transplant must be Preauthorized by WINhealth Partners and must be provided in a Designated Organ Transplant Facility.
- Coverage for transplants will not be provided when resulting from a condition that is not covered by WINhealth Partners.
- Transportation and lodging expenses shall not exceed $5,000 per transplant.
- Post transplant prescription drugs are subject to the regular prescription Copayments and/or Coinsurance.
- Repeat pre-transplant evaluations at the same or another transplant center are not Covered Services if the Member has previously been determined not to be a candidate by a WINhealth Partners' Designated Organ Transplant Facility.

32. URGENT CARE

Covered

Urgent Care is for Conditions that are not emergent but need immediate medical attention within twenty-four (24) to forty-eight (48) hours when a Member does not have ready access to a Participating Primary Care Physician. Services rendered by a Participating Urgent Care Provider do not require Preauthorization. Participating Urgent Care Providers are listed in the provider directory.

Obtaining Urgent Healthcare Services - In a situation that is not an Emergency, if a Member requires Urgent Healthcare Services, the Member should go to the nearest Urgent Care Facility for treatment. If the Urgent Care Facility is Non-Participating, then the Member must first notify WINhealth Partners. Urgent Healthcare Services rendered by a Non-Participating Provider must be Preauthorized by WINhealth Partners.

Limits

- Urgent care visits are subject to the Copayment listed in the Schedule of Benefits.
- Urgent care visits that are rendered by Non-Participating Providers are covered only when Medically Necessary and Preauthorized.
- Out of area follow-up care at an Urgent Care Facility is not a Covered Service.

II. BENEFIT PLAN EXCLUSIONS AND LIMITATIONS

The following services are not covered or are subject to limitations:

- **Alcoholism and Substance Abuse services** except for wellness counseling done by a Participating primary care Physician and offered in accordance with the preventative services schedule listed in Section 6.21
- **Alternative/complementary therapies**
- **Any service**, treatment, procedure, facility, equipment, drug, drug usage, device or supply that is inconsistent with generally accepted principals of professional medical practice
- **Artificial aids** including speech synthesis devices except items identified in the Evidence of Coverage
- **Athletic trainers**
- **Autopsies** and/or transportation costs for deceased Members
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be puréed for oral or tube feedings
- **Benefits and services not specified as Covered Services**
- **Biofeedback**
- **Breast Reduction and Breast Augmentation surgery**
- **Care for Conditions which State or local law requires** to be treated in a public or correctional facility
- **Care for military service connected disabilities** to which the Member is legally entitled to receive treatment and for which facilities are reasonably available to the Member
- **Care for any Condition** which an insured would have no legal obligation to pay in the absence of this or any similar Coverage or that is rendered by a provider who is a member of the insured's immediate family
- **Care or treatment of an Injury** incurred in connection with war or any act of war, whether declared or undeclared; any act of terrorism; sickness, or treatment of a medical condition arising out of service in the armed forces or units auxiliary thereto; or participation in a felony with a conviction, assault, riot, or insurrection
- **Charges above Reasonable and Customary charges**
- **Charges for failure** to keep a scheduled visit, charges for completion of any form or charges for medical information
- **Circumcisions** performed other than during the newborn's Hospital stay, unless Medically Necessary
- **Clothing** or other protective devices including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not
- **Co-dependency** treatment
- **Convenience items** and personal hygiene items such as, but not limited to, air conditioners, humidifiers or physical fitness equipment
- **Complications or side effects** arising from services, procedures, or treatments excluded by this policy
- **Cosmetic Surgery, treatments, devices, orthotics, and medications,** including surgery and any related services intended solely to improve appearance but not restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies or for the correction of, or complications arising from, treatment or an operation to improve appearance if the original treatment or operation either was not a covered expense

under this Health Plan of benefits or would not have been covered if the patient had been insured

- **Costs for extended warranties** and premiums for other insurance coverage
- **Counseling** except for wellness counseling done by a Participating Primary Care Physician and offered in accordance with the preventative services schedule listed in Section 6.21
- **Court ordered evaluation or treatment**
- **Covered Services obtained from a Non-Participating Provider/Practitioner** except as provided in the Evidence of Coverage and as Preauthorized by WINhealth Partners
- **Custodial or Domiciliary care** or rest cures or treatment in a facility or part of a facility that is mainly a place for rest convalescence, Custodial Care, the aged, the care or treatment of alcoholism or drug addiction, or training schooling, or occupational therapy
- **Dental care** and dental x-rays, except as provided in the Evidence of Coverage
- **Dental implants**
- **Disposable medical supplies**, except when provided in a Hospital or Physician's office or by a home health professional
- **Donor Sperm**
- **Durable Medical Equipment/Prosthetics/Orthotics –** Additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, loss, neglect, theft, misuse, abuse, to improve appearance, or for convenience or items under the manufacturer or supplier's warranty
- **Elastic support hose**
- **Emergency facility** used for non-emergent services
- **Exercise equipment** and videos, personal trainers, club memberships, and weight reduction programs
- **Experimental or investigational** drugs, medicines, treatments, or procedures devices and/or drugs shall be deemed excluded (not Covered) as Experimental, Investigational, Unproven, Unusual or Not Customary if:
  - It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
  - It is the subject of a current Investigational new drug or new device application on file with the FDA; or,
  - It is being provided pursuant to a Phase I or Phase II Clinical Trial or as the Experimental or research arm of a Phase III Clinical Trial; and is not otherwise a Covered Service, or,
  - It is being provided pursuant to a written protocol that describes among its objectives, determinations of safety, toxicity, effectiveness in comparison to conventional alternatives; or,
  - It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by Federal Regulations, particularly those of the FDA or the Department of Human Health Services (HHS); or,
  - The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; or,
  - The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or,
  - It is Experimental, Investigational, Unproven, Unusual or not a generally acceptable medical practice in the predominant opinion of independent experts; or,
  - A majority of a representative sample of not less than three (3) health insurance or benefit providers or administrators consider the requested treatment, procedure, device or drugs to be Experimental, Investigational, Unproven, Unusual, or Not Customary

based upon criteria and standards regularly applied by the industry; or it is not Experimental or Investigational in itself pursuant to the above, and would not be Medically Necessary, but for being provided in conjunction with the provision of a treatment, procedure, device or drug which is Experimental, Investigational, Unproven, Unusual or Not Customary.
    - A nationally recognized resource including, but not limited to, Hayes Inc., DATTA or other recognized source has deemed that Healthcare Services to be Experimental, or Investigational. All such determinations shall be final, conclusive and binding.
- **Extracorporeal shock wave therapy**
- **Eye movement therapy**
- **Eye refractive procedures,** including radial keratotomy, laser procedures and other techniques
- **Eyeglasses (corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof
- **Foot care (routine)**, except as provided in the Evidence of Coverage
- **Foot orthotics** functional and/or customized except as described in the Evidence of Coverage
- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided
- **Gloves,** unless part of a wound treatment kit
- **Hair-loss** (or baldness) treatments, medications, supplies, and devices including wigs, and special brushes
- **Halfway houses**
- **Healthcare Services that are not a Covered Service** regardless of the recommendation or order by a Participating or Non-Participating Provider
- **Health fair services**
- **Hearing aids** and the evaluation for the fitting of hearing aids or cochlear implants
- **Hospice benefits are not available for the following services**: food, housing, and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under Durable Medical Equipment) homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling, or bereavement counseling.
- **Hospital, physician, mid-wife** and other charges related to prenatal care and delivery of a newborn child except as provided in this Evidence of Coverage
- **Hypnotherapy**
- **Infant formula**
- **Infertility treatment/Artificial Conception and drugs**
- **In-vitro, GIFT and ZIFT fertilization**
- **Lithotripsy of plantar fascia for plantar fasciitis**
- **Malocclusion treatment**, if part of routine dental care and orthodontics
- **Maternity/Obstetrical Care** including, but not limited to, any condition which is pregnancy related, prenatal care, delivery and postnatal care, including conception in dependent Children
- **Massage Therapy**
- **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Member or when the transplant procedure is not a Covered Service
- **Mental Health Services**
- **New medications** for which the determination of criteria for Coverage has not yet been established by WINhealth Partners' Pharmacy and Therapeutics Committee

- **Nutritional supplements**
- **Organ transplants (Non-human),** except for porcine (pig) heart valve
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**
- **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges, and denture used for the treatment of Craniomandibular (CMJ) and Temporomandibular Joint (TMJ) disorders
- **Orthomolecular therapy** including nutrients, vitamins, and food supplements
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies
- **Over-the-counter medications** except as specifically mentioned in Section 6(20)
- **Personal or comfort items, services or treatments**
- **Photopheresis** for all conditions other than mycosis fungoides
- **Physical examinations**, vaccinations, drugs, and immunizations for the primary intent of medical research or for purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports, or functional capacity examinations related schooling, sports, or employment
- **Prescriptions** purchased at a Non-Participating Pharmacy
- **Prescription Drug** replacements due to loss, theft or destruction
- **Prescription Drugs** received upon Hospital discharge or provided by a Hospital pharmacy
- **Prescription Drugs** hormone replacement therapy (including estrogen, testosterone or progesterone) or compounded medications
- **Prescription Drugs requiring Preauthorization when Preauthorization was not obtained**
- **Private duty nursing**
- **Psychological testing**
- **Reduction mammoplasty**
- **Residential Treatment Centers**
- **Reversals of voluntary sterilization**
- **Services for which the Member is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member
- **Services incurred** after the Termination Date of the Member's Coverage
- **Smoking cessation**, except as designed within the WINhealth Wellness Program or except for wellness counseling done by a Participating primary care Physician and offered in accordance with the preventative services schedule listed in Section 6(21)
- **Covered Services requiring Preauthorization** when Preauthorization was not obtained
- **Sex transformation surgery and drugs related to sex transformation**
- **Sexual dysfunction treatment**, including medication, counseling and clinics
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies, or behavioral or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances.
- **Special medical foods**
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes or other human tissue
- **Substance Abuse Treatment** except for wellness counseling done by a Participating primary care Physician and offered in accordance with the preventative services schedule listed in Section 6(21)

- **Surgical or chemical treatment of skin tags, or common warts, except genital or plantar warts**
- "**Telephone visits"** by Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient
- **Travel and lodging** expenses, except as provided in the Evidence of Coverage
- **Treatment for autistic disease, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation**
- **Treatment for ADD/ADHD,** including initial medical diagnosis, or for inpatient Confinement for environmental changes
- **Treatment for Injuries or Illness caused by a Member's intoxication over the legal limit, non-prescribed use of controlled substances, intention to Injure his or herself or another, or culpable negligence while sane or insane**
- **Vision Care (routine) and eye refractions** for determining prescriptions for corrective lenses except as provided in this Evidence of Coverage
- **Visual training**
- **Vocational Rehabilitation services and Long-Term Rehabilitation services**
- **Weight reduction or control treatments and medications** including gastric bypass surgery or gastric banding
- **Work related accidents or Injuries or occupational Illness or disease** if the Member is required to be covered under Workers' Compensation insurance whether or not such coverage actually exists