

provides coverage of prescription medication shall provide coverage for each drug that satisfies all of the following:

1. Is prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection.

2. Is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33.

3. If the drug is an investigational new drug described in subd. 2., is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36.

(c) Coverage of a drug under par. (b) may be subject to any copayments and deductibles that the disability insurance policy applies generally to other prescription medication covered by the disability insurance policy.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A medicare replacement policy or a medicare supplement policy.

(10) LEAD POISONING SCREENING. (a) Except as provided in par. (b), every disability insurance policy and every health care benefits plan provided on a self-insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district under s. 120.13 (2) shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health services under s. 254.158.

(b) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

3. A long-term care insurance policy, as defined in s. 600.03 (28g).

4. A medicare replacement policy, as defined in s. 600.03 (28p).

5. A medicare supplement policy, as defined in s. 600.03 (28r).

(11) TREATMENT FOR THE CORRECTION OF TEMPOROMANDIBULAR DISORDERS. (a) Except as provided in par. (c), every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury.

2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

(b) 1. The coverage required under this subsection for nonsurgical treatment includes coverage for prescribed intraoral splint therapy devices.

2. The coverage required under this subsection does not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

(c) 1. The coverage required under this subsection may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

2. Notwithstanding subd. 1., the coverage required under this subsection for diagnostic procedures and medically necessary nonsurgical treatment for the correction of temporomandibular disorders may not exceed \$1,250 annually.

(d) Notwithstanding par. (c) 1., an insurer or a self-insured health plan of the state or a county, city, village, town or school district may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only dental care.

2. A medicare supplement policy, as defined in s. 600.03 (28r).

(12) HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE. (a) In this subsection, "ambulatory surgery center" has the meaning given in 42 CFR 416.2.

(b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, shall cover hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

1. The individual is a child under the age of 5.

2. The individual has a chronic disability that meets all of the conditions under s. 230.04 (9r) (a) 2. a., b. and c.

3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

(c) The coverage required under this subsection may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured plan.

(d) This subsection does not apply to a disability insurance policy that covers only dental care.

(12m) TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection:

1. "Autism spectrum disorder" means any of the following:

a. Autism disorder.

b. Asperger's syndrome.

c. Pervasive developmental disorder not otherwise specified.

2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self-insured health plan.

3. "Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

4. "Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

5. "Physician" has the meaning given in s. 146.34 (1) (g).

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(b) Subject to pars. (c) and (d), and except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:

1. A psychiatrist, as defined in s. 146.34 (1) (h).
2. A person who practices psychology, as described in s. 455.01 (5).
3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m).
4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3.
5. A professional working under the supervision of an outpatient mental health clinic certified under s. 51.038.
6. A speech-language pathologist, as defined in s. 459.20 (4).
7. An occupational therapist, as defined in s. 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide at least \$50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least \$25,000 for nonintensive-level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register.

2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1., need not be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.
2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).
3. A long-term care insurance policy.
4. A medicare replacement policy or a medicare supplement policy.

(f) 1. The commissioner shall by rule further define "intensive-level services" and "nonintensive-level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and

is not required to provide a finding of emergency for a rule promulgated under this subdivision.

(13) BREAST RECONSTRUCTION. (a) Every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of the surgical procedure known as a mastectomy shall provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

(b) The coverage required under par. (a) may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

(14) COVERAGE OF IMMUNIZATIONS. (a) In this subsection:

1. "Appropriate and necessary immunizations" means the administration of vaccine that meets the standards approved by the U.S. public health service for such biological products against at least all of the following:

- a. Diphtheria.
- b. Pertussis.
- c. Tetanus.
- d. Polio.
- e. Measles.
- f. Mumps.
- g. Rubella.
- h. Hemophilus influenza B.
- i. Hepatitis B.
- j. Varicella.

2. "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full-time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village or school district, that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

(c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.
2. A disability insurance policy that covers only hospital and surgical charges.
3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long-term care insurance policy, as defined in s. 600.03 (28g).

5. A medicare replacement policy, as defined in s. 600.03 (28p).

6. A medicare supplement policy, as defined in s. 600.03 (28r).

(15) COVERAGE OF STUDENT ON MEDICAL LEAVE. (a) Subject to pars. (b) and (c), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of the insured because the person is a full-time student, including the coverage under s. 632.885 (2) (b), shall continue to