This document is a sample of the basic terms of coverage under a Choice Plus product. Your actual benefits will depend on the plan purchased by your employer.

Certificate of Coverage

All Savers Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between All Savers Insurance Company and the Employer to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Employer's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

1. the Group Policy;
2. the *Schedule of Benefits*;
3. the Employer's application;
4. the Employee enrollment form;
5. Riders, including the Outpatient Prescription Drug Rider, [the Pediatric Dental Rider] [and the Pediatric Vision Care Services Rider]; and
6. Amendments.

You can review the Policy at the office of the Employer during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of the *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

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 12:01 a.m. in the time zone of the Employer'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 [state name]. The Policy is governed by ERISA unless the Employer is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [state name] are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with Section 1: Covered Health Services and Section 2: Exclusions and Limitations. You should also carefully read Section 8: General Legal Provisions to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Employer, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

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 Section 9: Defined Terms. You can refer to Section 9: 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 All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in Section 9: Defined Terms.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Service listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in Section 3: When Coverage Begins. To be enrolled with us and receive Benefits, both of the following apply:

1. your enrollment must be in accordance with the Policy issued to your Employer, including the eligibility requirements; and

2. you must qualify as a Subscriber or his or her Dependent as those terms are defined in Section 9: Defined Terms.

Your Employer may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Employer.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment, Annual Deductible, and/or Coinsurance for most Covered Health Services. When applicable, these payments may be due at the time of service or when billed by the Physician, provider or facility. Copayment, Annual Deductible, and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review Section 2: Exclusions and Limitations to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in Section 5: How to File a Claim.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

1. interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments; and

2. make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in Section 1: Covered Health Services and in the *Schedule of Benefits*, unless the service is excluded in Section 2: Exclusions and Limitations. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See Section 5: How to File a Claim.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, at our sole discretion, in accordance with one or more of the following methodologies:

1. [a calculation based upon the Medicare allowable amount or an independently published database; or

2. an amount based on the following:

    a. the type of medical service;

    b. the geographic area where the medical service is provided; and

    c. other applicable related factors.

We update the formula on a periodic basis based on a collection of factors including, but not limited to, the following:]

1. [as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);

2. as reported by generally recognized professionals or publications;

3. as used for Medicare; or

4. as determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.]

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the reimbursement policies are applied to provider billings. We share the reimbursement policies with Physicians and other providers in the Network through the provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of the reimbursement policies does not reimburse (in whole or in part) for the service billed. [You may obtain copies of the reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to [www.myallsavers.com] or] by calling Customer Service at the telephone number on your ID card.]

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

1. Covered Health Services are received while the Policy is in effect;

2. Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4: When Coverage Ends occurs; and

3. the person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

If you receive services or supplies that are not Covered Health Services under the Policy, whether from a Network provider or a non-Network provider, you are responsible for making the full payment to that provider.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

1. the amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance);

2. any limit that applies to these Covered Health Services (including visit, day and/or dollar limits on services);

3. any limit that applies to the amount you are required to pay in a [Calendar][Plan] Year (Out-of-Pocket Maximum); and

4. any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

1. from a non-Network Hospital to a Network Hospital; or

2. to a Hospital that provides a higher level of care that was not available at the original Hospital.

Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.

- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Chiropractic Treatment

Manipulative therapy to restore normal function to the nerve system and body structures including, but not limited to:

1. manipulation;
2. myofascial release; or
3. soft tissue mobilization.

Benefits are available for the cost to evaluate the need and extent of these therapies.

Benefits under this section do not include:

1. maintenance care;
2. treatment and services for community re-entry;
3. transitional living;
4. residential living programs; or
5. work-hardening programs.

Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip, and knees which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below[;][.]
- [other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications;

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

1. the Experimental or Investigational Service or item. The only exceptions to this are:

    a. certain Category B devices;

    b. certain promising interventions for patients with terminal illnesses;

    c. other items and services that meet specified criteria in accordance with our medical and drug policies.

2. items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine[,] [and] hip and knees [and other diseases or disorders] which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).);

    b. Centers for Disease Control and Prevention (CDC);

    c. Agency for Healthcare Research and Quality (AHRQ);

    d. Centers for Medicare and Medicaid Services (CMS);

    e. a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);

    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

    g. the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

        a. comparable to the system of peer review of studies and investigations used by the National Institutes of Health;

        b. ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;

- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial;

- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[Complications of Pregnancy]

[Benefits for Complications of Pregnancy include all Covered Health Services incurred after the onset of the Complication of Pregnancy. Benefits will be provided for you and your Enrolled Dependent spouse or daughter.

Complications of Pregnancy are explained in Section 9: Defined Terms. Benefits for Complications of Pregnancy do not include services related to a normal Pregnancy or a vaginal delivery.]

Dental Services - Accident Only

Dental services when all of the following are true:

1. treatment is necessary because of accidental damage;

2. dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry; and

3. the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

4. treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care); and

5. treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

1. Emergency examination;

2. necessary diagnostic X-rays;

3. endodontic (root canal) treatment;

4. temporary splinting of teeth;

5. prefabricated post and core;

6. simple minimal restorative procedures (fillings);

7. extractions;

8. post-traumatic crowns if such are the only clinically acceptable treatment; or

9. replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items
Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to the following:

1. blood glucose monitors;
2. insulin syringes with needles;
3. blood glucose and urine test strips;
4. ketone test strips and tablets; or
5. lancets and lancet devices.

Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment and Ostomy Supplies.

Durable Medical Equipment and Ostomy Supplies

Durable Medical Equipment that meets each of the following criteria:

1. ordered or provided by a Physician for outpatient use primarily in a home setting;
2. used for medical purposes;
3. not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment; and
4. not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

1. equipment to assist mobility, such as a walker, cane, or standard wheelchair;
2. a standard hospital-type bed;
3. oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks);
4. delivery pumps for tube feedings (including tubing and connectors);
5. braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage;
6. mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage);
7. burn garments; and
8. insulin pumps and all related necessary supplies as described under *Diabetes Services*.

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

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

1. Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect; and

2. Benefits are not available to replace lost or stolen items.

Benefits for ostomy supplies are limited to the following:

1. pouches, face plates and belts;

2. irrigation sleeves, bags and catheters; and

3. skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Services are available 24 hours per day, seven days per week. If you require Emergency Health Services, go to the nearest emergency room or call 911 for assistance.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. If you choose to stay in the non-Network Hospital after the date you are stabilized, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

[Hearing Aids]

[Benefits are provided for Hearing Aids required for the correction of a Hearing Impairment and charges for associated fitting and testing. The Hearing Aid must be purchased as a result of a written recommendation by a Physician.

Covered Health Services are limited to a single purchase, including repair/replacement, every three years.

If more than one hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits for bone anchored hearing aids (BAHA) are a Covered Health Service for which Benefits are provided under the applicable medical/surgical benefit categories in the *Certificate* only for Covered Persons who have either of the following:

1. craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable Hearing Aid; or

2. hearing loss of sufficient severity that it would not be adequately remedied by a wearable Hearing Aid.

Benefits for BAHA are limited to one per Covered Person during the entire period of time the Covered Person is enrolled under the *Policy* and include repairs and/or replacement only if the BAHA malfunctions.]

Home Health Care

Services received from a Home Health Agency that are both of the following:

1. ordered by a Physician; and

2. provided in your home by a registered nurse, therapist, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required. A service is not considered to be "skilled" care simply because there is not an available caregiver.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

1. it must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;

2. it is ordered by a Physician;

3. it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;

4. it requires clinical training in order to be delivered safely and effectively; and

5. it is not Custodial Care.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the Terminally Ill. Hospice care includes physical, psychological, social and spiritual care for the Terminally Ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

1. supplies and non-Physician services received during the Inpatient Stay; and

2. room and board in a Semi-private Room.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

1. lab and radiology/X-ray; and

2. mammography.

Benefits under this section include:

1. the Physician and facility charge: and

2. the charge for supplies and equipment.

Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services.

Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

1. the Physician and facility charge; and

2. the charge for supplies and equipment.

[Maternity Services]

[Benefits for Covered Health Services incurred by you or your Enrolled Dependent spouse or daughter for a normal Pregnancy and for childbirth. Benefits include Covered Health Services for a cesarean section.

We will provide these Benefits on the same basis as we pay for Benefits for a Sickness, according to:

1. guidelines established by the American College of Obstetricians and Gynecologists; or

2. any other established professional medical association.

For inpatient care at a Hospital, we will provide Benefits for the mother for up to:

1. 48 hours following a vaginal delivery; or

2. 96 hours following an elective or scheduled cesarean section.

The mother is not required:

1. to give birth in a Hospital; or

2. to stay in the Hospital for these minimum hours.

The above hours do not prohibit the mother and her Physician from both deciding on an earlier discharge.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital for the birth. A determination of whether to admit the mother to a Hospital for childbirth is made by the Physician.

For purposes of this provision, a Physician may be a person such as a nurse midwife or a physician assistant, who is:

1. licensed under applicable state law to provide maternity care;

2. directly responsible for providing maternity care to the mother; and

3. providing the care.

For purposes of this provision, a Hospital includes a licensed, free-standing birthing facility that provides services for:

1. prenatal care;

2. delivery;

3. immediate postpartum care; and

4. care of the child born at the center.

Covered Health Services incurred at a free standing birthing facility within 24 hours after admission will not be subject to any out-of-pocket expense amount. After the initial 24 hours, Benefits are provided on the same basis as maternity Benefits received at a Hospital. The same inpatient care time periods apply for maternity care received at a free standing birthing facility as for similar care received at a Hospital.

We will provide Benefits for Complications of Pregnancy the same as for a Sickness.

Follow-up Care

We will provide Benefits for Physician-directed follow-up care. We will provide Benefits for follow-up care on the same basis as we pay for Benefits for a Sickness.

Follow-up care services include:

1. physical assessment of the mother and newborn;

2. parent education;

3. assistance and training in breast or bottle feeding;

4. assessment of the home support system;

5. performance of any Medically Necessary and appropriate clinical tests; and

6. any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Benefits apply to services provided in a medical setting or through home health care visits. Benefits apply to a home health care visit only if the health care provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When the mother and her Physician decide to shorten the length of the Inpatient Stay to less than the number of hours required under this maternity benefit and the newborn well baby care benefit, we will provide Benefits for all follow-up care that is provided within 72 hours after discharge.

When the mother or newborn receives at least the number of hours of inpatient care required to be covered, we will only provide Benefits for follow-up care that is determined to be Medically Necessary by the health care provider responsible for discharging the mother or newborn.

Newborn Well Baby Care
Benefits for newborn well baby care are provided on the same basis as Benefits for a Sickness.

We will provide Benefits for newborn well baby care that meets the definition of a Preventive Care Service, as defined in the *Certificate of Coverage*, on the same basis as for Preventive Care Services.

The newborn charges will be paid separately from the mother's charges. Each newborn as Dependent must meet any applicable Copayment, Annual Deductible, and Coinsurance amount under the Policy.

We will provide Benefits for newborn well baby care according to:

1. guidelines established by the American Academy of Pediatrics; or
2. any other established professional medical association.

Newborn well baby care services include:

1. Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital on its own behalf;
2. Physician charges for circumcision; and
3. Physician charges for the initial routine exam of the child before discharge from the Hospital.

We will provide Benefits for newborn well baby care for up to:

1. 48 hours of the child's life for a vaginal delivery; or
2. 96 hours of the child's life for a cesarean section,

but we will never provide benefits for newborn well baby care after the mother is discharged from the Hospital.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery.

If delivery occurs outside of a Hospital, the 48 or 96 hours begin when the newborn is admitted to the Hospital for the birth. A determination of whether to admit the newborn to a Hospital is made by the Physician.

For purposes of this provision, a Physician is a person who is:

1. licensed under applicable state law to provide pediatric care;
2. directly responsible for providing pediatric care to the child; and
3. providing the care.

Important: To continue insurance for the child, you must enroll the child under the plan as required under Adding New Dependents in Section 3: When Coverage Begins in the *Certificate of Coverage*. If you do not enroll the child as required, coverage for the child will terminate at the end of the enrollment period.]

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Benefits will be provided for the following Covered Health Services to treat a Mental Health Condition:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits will not be provided for:

1. any medical services to treat addiction to or abuse of tobacco or nicotine;
2. any medical services to treat weight loss or weight gain, except for anorexia nervosa or bulimia;
3. marriage counseling;
4. family counseling unless it is directly related to a Mental Health Condition for which you are being treated; or
5. the cost of educational presentations, videos or printed materials for Mental Health Conditions.

Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical Services

Covered Health Services include Physician fees for surgical procedures received on an outpatient or inpatient basis in a [Physician's office,] Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Benefits under this provision include fees for services rendered by a Physician surgical assistant and/or a non-Physician surgical assistant. When multiple surgical procedures are done at the same time, Covered Health Services will include the Eligible Expense for the first or major procedure and one-half of the Eligible Expense for each additional procedure. For a Physician surgical assistant, payment is limited to 20% of the Eligible Expense for the first or major surgical procedure and 10% of the Eligible Expense for additional procedures. For a non-Physician surgical assistant, payment is limited to [10-50]% of the Eligible Expense for the first or major procedure and [5-50]% of the Eligible Expense for each additional procedure.

Benefits under this section also include anesthesia services.

Benefits are not payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

[When these services are performed in a Physician's office, Benefits are described under Physician's Visit - Sickness and Injury.]

Physician's Visit - Sickness and Injury

Services provided by a Physician for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the service is rendered in a clinic, an Alternate Facility or a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

1. education is required for a disease in which patient self-management is an important component of treatment; and

2. there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under Preventive Care Services.

Benefits under this section also include a second opinion [and surgical services performed in a Physician's office].

Each Physician who gives a second opinion:

1. must be a specialist for the Injury or Sickness; and

2. cannot be financially connected with the other Physician(s).

Preventive Care Services

Benefits are provided for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital for:

1. items or services that have an A or B rating in current recommendations of the United States preventive Services Task Force;

2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supports by the Health Resources and Services Administration (HRSA); and

4. additional preventive care and screening, with respect to women, provided for in guidelines supported by HRSA.

   Benefits defined under this requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

   a. Which pump is the most cost effective.

   b. Whether the pump should be purchased or rented.

Examples of preventive medical care are:

Physician office services:

1. routine physical examinations;

2. well baby and well child care;

3. immunizations;

4. hearing screening; and

5. voluntary family planning services.

Lab, X-ray or other preventive tests:

1. cervical cancer screening;

2. prostate cancer screening; and

3. bone mineral density tests.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

1. artificial arms, legs, feet and hands;

2. artificial face, eyes, ears and noses;

3. speech aid prosthetics and tracheo-esophageal voice prosthetics; and

4. breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

1. there are no Benefits for repairs due to misuse, malicious damage or gross neglect; and

2. there are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications at all stages of mastectomy including lymphedemas, are provided in the same manner and at the same level as those for any other Covered Health Service.

Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services, including habilitative services, limited to:

1. physical therapy;

2. occupational therapy;

3. speech therapy;

4. pulmonary rehabilitation therapy;

5. cardiac rehabilitation therapy; and

6. post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Habilitative Services

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment and Ostomy Supplies* and *Prosthetic Devices*.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient Facility. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include the facility charge and the charge for supplies and equipment.

[When these services are performed in a Physician's office, Benefits are described under Physician's Visit - Sickness and Injury.]

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

1. supplies and non-Physician services received during the Inpatient Stay; and
2. room and board in a Semi-private Room.

Please note that Benefits are available only if both of the following are true:

1. if the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital; and
2. you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

1. it must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;

2. it is ordered by a Physician;

3. it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and

4. it requires clinical training in order to be delivered safely and effectively.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Covered Health Services to treat Substance Use Disorders include the following:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

We determine coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits will not be provided for:

1. any medical services to treat addiction to or abuse of tobacco or nicotine; or

2. the cost of educational presentations, videos or printed materials for Substance Use Disorders.

Surgery - Outpatient Facility

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office].

Benefits under this provision include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this provision include the facility charge and the charge for supplies and equipment.

[When these services are performed in a Physician's office, Benefits are described under Physician's Visit - Sickness and Injury.]

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

1. education is required for a disease in which patient self-management is an important component of treatment; and

2. there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include the facility charge and the charge for related supplies and equipment.

[When these services are performed in a Physician's office, Benefits are described under Physician's Visit - Sickness and Injury.]

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, double lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, bowel, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

If you are required to receive transplantation services at a Designated Facility outside your geographic area, we will provide travel and lodging in accordance with our guidelines.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Visit - Sickness and Injury.

[Voluntary Sterilization Procedures]

[We will also provide Benefits for voluntary sterilization procedures [, for you and for your Enrolled Dependent spouse. We will not provide benefits for your Enrolled Dependent child].]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

1. it is recommended or prescribed by a Physician; or

2. it is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: Covered Health Services or through a Rider to the *Certificate*.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in Section 1: Covered Health Services, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.

2. Aromatherapy.

3. Hypnotism.

4. Massage therapy.

5. Rolfing.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in Section 1: Covered Health Services.

Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services.*

1. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

2. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

4. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Note to Filer: *Applies when state does not require benefits for expanded autism spectrum disorder. Delete this note prior to filing.*

[7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

   a. transplant preparation;

   b. prior to the initiation of immunosuppressive drugs; and

   c. the direct treatment of cancer or cleft palate.

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   a. extraction, restoration and replacement of teeth;

   b. medical or surgical treatments of dental conditions; and

   c. services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.

3. Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.

3. The following items are excluded, even if prescribed by a Physician:

   a. blood pressure cuff/monitor;

   b. enuresis alarm;

   c. home coagulation testing equipment;

d. non-wearable external defibrillator;

e. trusses;

f. ultrasonic nebulizers;

g. ventricular assist devices.

4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.

5. Oral appliances for snoring.

6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   a. cleaning and soaking the feet; and

   b. applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.

5. Bunions.

6. Hammertoe.

7. Treatment of subluxation of the foot.

8. Shoes.
9. Shoe orthotics.
10. Shoe inserts.
11. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
    a. elastic stockings;
    b. ace bandages;
    c. gauze and dressings; and
    d. urinary catheters.

    This exclusion does not apply to:

    i. Disposable supplies necessary for the effective use of Durable Medical Equipment and ostomy supplies for which Benefits are provided as described under Durable Medical Equipment and Ostomy Supplies in Section 1: Covered Health Services.

    ii. Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment and Ostomy Supplies in Section 1: Covered Health Services.

Mental Health Services

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

11. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Nutrition

1. Individual and group nutritional counseling except when provided by a Network provider. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

    a. nutritional education is required for a disease in which patient self-management is an important component of treatment; and

    b. there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

    a. air conditioners, air purifiers and filters, dehumidifiers;

    b. batteries and battery chargers;

    c. breast pumps; (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)

    d. car seats;

    e. chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;

    f. electric scooters;

    g. exercise equipment;

    h. home modifications such as elevators, handrails and ramps;

    i. hot tubs;

    j. humidifiers;

    k. jacuzzis;

    l. mattresses;

    m. medical alert systems;

    n. motorized beds;

    o. music devices;

    p. personal computers;

    q. pillows;

r. power-operated vehicles;

s. radios;

t. saunas;

u. stair lifts and stair glides;

v. strollers;

w. safety equipment;

x. speech generating devices;

y. treadmills;

z. vehicle modifications such as van lifts;

aa. video players; and

bb. whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 9: Defined Terms. Examples include:

   a. pharmacological regimens, nutritional procedures or treatments;

   b. scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);

   c. skin abrasion procedures performed as a treatment for acne;

   d. liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;

   e. treatment for skin wrinkles or any treatment to improve the appearance of the skin;

   f. treatment for spider veins; and

   g. hair removal or replacement by any means.

2. Breast implants or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1: Covered Health Services.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.

5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

7. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.

5. Psychosurgery.

6. Sex transformation operations.

7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

8. Biofeedback.

9. Services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer or as necessary to safeguard a Covered Person's health due to a non-dental physiological impairment. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.

11. Surgical and non-surgical treatment of obesity.

12. Stand-alone multi-disciplinary smoking cessation programs.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    a. has not been actively involved in your medical care prior to ordering the service, or

    b. is not actively involved in your medical care after the service is received.

4. Foreign language and sign language interpreters.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. [Voluntary sterilization [for an Enrolled Dependent child].]

5. The reversal of voluntary sterilization.

6. [Health services and associated expenses for surgical, non-surgical, or drug-induced pregnancy termination. This exclusion does not apply to treatment of a molar pregnancy, ectopic pregnancy, or missed abortion (commonly known as a miscarriage).]

7. [Contraceptive supplies and services.]

8. Fetal reduction surgery.

9. [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

Substance Use Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Transplants

1. Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1: Covered Health Services.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to Transplantation Services described in Section 1: Covered Health Services or ambulance transportation for which Benefits are available as described under Ambulance Services in Section 1: Covered Health Services.

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.

2. Custodial Care.

3. Domiciliary care.

4. Private duty nursing. This means 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; or

c. the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

2. Routine vision examinations, including refractive examinations to determine the need for vision correction.

3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

4. [Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.]

[5.] Eye exercise therapy.

[6.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

   a. required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption;

   b. related to judicial or administrative proceedings or orders;

   c. conducted for purposes of medical research; or

   d. required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. Charges in excess of Eligible Expenses or in excess of any specified limitation.

7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

8. Autopsy.

Section 3: When Coverage Begins

How to Enroll
Eligible Persons must complete an enrollment form. The Employer will give the necessary forms to you. The Employer will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins
If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage
The Employer determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person
Eligible Person usually refers to an Employee or member of the Employer who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Employer and Subscriber, see Section 9: Defined Terms.

Eligible Persons must reside within the United States.

Dependent
Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 9: Defined Terms.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

Coverage for Children under a Qualified Medical Child Support Order
When you are required by a Qualified Medical Child Support Order to provide medical insurance for a child when you do not have custody of the child, we will:

1. permit you to enroll the child for medical insurance under the plan without regard to any enrollment period restrictions; and

2. add the child to the plan for medical insurance, upon enrollment made by the child's custodial parent, by the state agency administering a Medicaid program, or by the state agency administering a child support enforcement program if you fail to enroll the child.

We will not add a child for medical insurance unless you are also insured by the plan.

We will not terminate the child's medical insurance unless we are provided satisfactory written evidence that:

1. the court or administrative order is no longer in effect;

2. the child is or will be enrolled in a comparable health plan with another insurer that will take effect not later than the termination date from this plan;

3. the required Premiums for the child are not paid by the Premium due date;

4. Dependent insurance is no longer available under the plan; or

5. you are no longer insured by the Policy.

We will:

1. provide information to the child's custodial parent(s) as may be necessary for the child to obtain Benefits under the plan;

2. permit the child's custodial parent(s), or the Physician with the custodial parents' approval to submit claims for Covered Health Services without your approval; and

3. make payments on such claims directly to the child's custodial parent(s), to the Physician, or to the state Medicaid agency.

Note: This *Certificate* does not provide all information about the procedures that we follow regarding Qualified Medical Child Support Orders. Upon request and at no cost, we will promptly provide a written description of the procedures.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Employer purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Employer determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by us if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by us if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

1. birth;

2. legal adoption;

3. placement for adoption;

4. marriage;

5. legal guardianship; or

6. court or administrative order.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because Premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

1. birth;

2. legal adoption;

3. placement for adoption; or

4. marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

1. the Eligible Person and/or Dependent becomes eligible for assistance in purchase of employment based coverage and requests coverage under this group medical plan no later than 60 days after the Eligible Person and/or Dependent becomes eligible for such assistance.

2. the Eligible Person and/or Dependent coverage terminates under Medicaid or a State child health plan as a result of loss of eligibility and requests coverage under this group medical plan no later than 60 days after the terminations of such coverage.

3. the Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and

4. coverage under the prior plan ended because of any of the following:

    a. loss of eligibility (including, but not limited to, legal separation, divorce, or death);

    b. the Employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Employer;

    c. in the case of COBRA continuation coverage, the coverage ended;

    d. the Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available;

    e. the plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent; or

    f. an Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

1. **The Entire Policy Ends**
   Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Employer is responsible for notifying you that your coverage has ended.

2. **You Are No Longer Eligible**
   Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 9: Defined Terms for complete definitions of the terms Eligible Person, Subscriber, Dependent and Enrolled Dependent.

3. **We Receive Notice to End Coverage**
   Your coverage ends on the last day of the calendar month in which we receive written notice from the Employer instructing us to end your coverage, or the last day of the calendar month of the date requested in the notice, if later. The Employer is responsible for providing written notice to us to end your coverage.

4. **Subscriber Retires or Is Pensioned**
   Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Employer's pension or retirement plan. The Employer is responsible for providing written notice to us to end your coverage.

   This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Employer's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Employer can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

Fraud or Intentional Misrepresentation of a Material Fact
You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.
During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if the Enrolled Dependent child:

1. is not able to be self-supporting because of mental or physical handicap or disability; and

2. depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Employers that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Employer is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Employer's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Employer or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Employer or its plan administrator are:

1. notifying you in a timely manner of the right to elect continuation coverage; and

2. notifying us in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Network providers must seek reimbursement from us and may charge you only for approved Copayments, Annual Deductible, Coinsurance or non-Covered Health Services.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you or the non-Network provider is responsible for requesting payment from us.

You or the non-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you or the non-Network provider do not provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, at our discretion. This time limit does not apply if you are legally incapacitated or if extenuating circumstances apply. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Notice of Claim

You must send us written notice of claim within 20 days from the date when you incur a claim. Failure to give notice within the 20 days does not invalidate or reduce a claim, if you can show us that it was not reasonably possible to give notice in that time, and you gave notice when reasonably possible.

We require the notice to include your name and address and the name of the person who incurred the claim.

Claim Forms

We do not require claim forms for medical insurance. However, we may require claim forms for other types of insurance. We will provide you with any claim form we require within 15 days from the date we receive notice of claim. If we do not provide a form in that time, you can satisfy the proof of loss requirement by sending us facts about the nature and extent of the claim.

Proof of Loss

We require written proof of loss. A written proof of loss is a bill from a health care provider. We must receive the proof within 90 days from the date of loss.

Failure to send the proof of loss to us in that time does not invalidate or reduce a claim if you can show us that it was not reasonably possible to send us proof of loss in that time, and you sent it when reasonably possible.

In any event, we must receive the proof of loss not later than 15 months from the date of loss, unless you are not legally competent to send it during that time.

Payment of Claim

We have the authority to automatically pay Benefits to Physicians or other providers. After we pay, we are discharged from paying any further Benefits to the extent of what we already paid.

If you want to receive direct payment of Benefits, you must notify us before we receive proof of loss.

We may be required to pay Benefits to your estate, to your Dependent's estate, or to someone who is a minor or is otherwise not legally competent. When this happens, we may pay an amount not to exceed $1,000 to a family member who we believe is equitably entitled to that amount. Any payment we make in good faith fully discharges Us, to the extent of that payment.

If we have documented proof that:

1. a Physician or other provider waived from their total fees a Copayment, Annual Deductible or Coinsurance amount that you are otherwise required to pay under the plan; then

2. we have the right to reduce the benefit amount we pay by the amounts waived by the Physician or other provider.

Time of Payment of Claim

We will pay or deny a claim when we receive a claim that includes all of the information necessary to process the claim subject to time review constraints under state law.

If additional supporting information is required to process the claim, we will notify the applicable person(s). This notice will detail the supporting documentation needed.

As applicable, the provider or both you and the provider will be notified when a claim is denied. The notification will include the reason(s) for the denial.

Assignment of Benefits

Except as described under the Payment of Claim provision, you cannot assign any other rights under the C*ertificate* to another party.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

The patient's name and the identification number from the ID card.

The date(s) of medical service(s).

The provider's name.

The reason you believe the claim should be paid.

Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

[For appeals of pre-service requests for Benefits as identified above, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

For appeals of post-service claims as identified above, the appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.]

[For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.]

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

[Federal External Review Program]

[If, after exhausting your internal appeals, you are not satisfied with the determination made by us, or if we fail to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of our determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

Clinical reasons.

The exclusions for Experimental or Investigational Services or Unproven Services.

Rescission of coverage (coverage that was cancelled or discontinued retroactively).

As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received our decision.

An external review request should include all of the following:

A specific request for an external review.

The Covered Person's name, address, and insurance ID number.

Your designated representative's name and address, when applicable.

The service that was denied.

Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). We have entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

A standard external review.

An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

A preliminary review by us of the request.

A referral of the request by us to the IRO.

A decision by the IRO.

Within the applicable timeframe after receipt of the request, we will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

Has exhausted the applicable internal appeals process.

Has provided all the information and forms required so that we may process the request.

After we complete the preliminary review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an IRO to conduct such review. We will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

All relevant medical records.

All other documents relied upon by us.

All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and we will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by us. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you

agree). The IRO will deliver the notice of Final External Review Decision to you and us, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing our determination, we will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.

Has provided all the information and forms required so that we may process the request.

After we complete the review, we will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an IRO in the same manner we utilize to assign standard external reviews to IRO*s*. We will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by us. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.]

Section 7: Coordination of Benefits

Coordination of Benefits

Medical insurance is subject to coordination of benefits. This provision applies when you are insured by other group plans, to avoid duplicate coverage for the same claim under This Plan.

Effect on Benefits

Determination of benefits payable under This Plan and all other applicable Plans is controlled by this Coordination of Benefits section, if without it, the sum of the benefits payable under This Plan and all other applicable Plans would exceed the Allowable Expense.

If the sum of benefits payable under This Plan and all other Plans exceeds the Allowable Expense, benefits payable by This Plan are reduced by the amount payable under the other Plans. Benefits of any other Plan which contains a coordination provision are ignored when computing benefits of This Plan, if the other Plan's provision states that its benefits are determined after the benefits of This Plan, and the rules set forth below require This Plan to compute its benefits first.

Allowable Expense includes any benefit that would have been payable by the other Plan if claim had been made.

Order of Benefit Determination

General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of This Plan; and

2. both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent
   The benefits of the Plan which covers the insured as an Employee, member or subscriber are determined before those of the Plan which covers the Covered Person as a dependent; except that if the Covered Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and Implementing regulations, Medicare is:

   a. secondary to the Plan covering the Covered Person as a dependent; and

   b. Primary to the Plan covering the Covered Person as other than a dependent (e.g., a retired Employee),

   then the benefits of the Plan covering the Covered Person as a dependent are determined before those of the Plan covering that Covered Person as other than a dependent.

2. Dependent Child/Parents not Separated or Divorced
   Except as stated in 3. below, when This Plan and another Plan cover the same child as a dependent of different persons, called parents:

   a. the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

   b. if both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based on gender of the parent, and if, as a result the Plans do not agree on the order of benefits, the rule in the other Plans will determine the order of benefits.

3. Dependent Child/Parents Separated or Divorced
   If two or more Plans cover a Covered Person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. first, the Plan of the parent with custody of the child;

b. then, the Plan of the spouse with the parent with custody;

c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This section does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint Custody
If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in 2. above.

5. Active/Inactive Employee
The benefits of a Plan which covers a Covered Person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Covered Person as a laid off or retired Employee. The same would hold true if a Covered Person is a dependent of a person covered as a retiree and an Employee. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage
If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

a. first, the benefits of a Plan covering the Covered Person as an Employee, member or subscriber (or as the Covered Person's dependent);

b. second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that Covered Person for the shorter term.

Effect on the Benefits of This Plan

When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the Order of Benefits Determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under This Plan in the absence of this Coordination of Benefits section; and

2. the benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this Coordination of Benefits section, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Necessary Information

We may require information to apply these coordination of benefits rules. To do this, we reserve the right to release or obtain from any insurance company, organization, or person any information we need, without your consent. At our request, you will furnish us with the information we need.

Facility of Payment

If another plan pays benefits, but this plan would have been primary, this plan will make the proper benefit adjustment. We reserve the right to pay the amount we determine to be warranted. The amount we pay is then considered a benefit payment by this plan. We are fully discharged from liability under this plan to the extent of that payment.

Right of Recovery

We reserve the right to recover any amount of benefit for an allowable expense under this plan if the amount we pay exceeds the amount we are required to pay. We also reserve the right to recover any amount of benefit that was paid in error. This right applies to us against any person to, for, or with respect to whom our payment was made and any other insurance company or organization that owes benefits for the same allowable expense under the other plan. We alone will determine against whom this right applies.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Employer's Benefit plan and how it may affect you. We help finance or administer the Employer's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

1. we do not decide what care you need or will receive. You and your Physician make those decisions;

2. we communicate to you decisions about whether the Employer's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*; and

3. the plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our Notice of Information Practices for details.

Our Relationship with Providers and Employers

The relationships between us and Network providers and Employers are solely contractual relationships between independent contractors. Network providers and Employers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Employers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Employer's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Employer's Benefit plan.

The Employer is solely responsible for all of the following:

1. enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);

2. the timely payment of the Policy Charge to us; and

3. notifying you of the termination of the Policy.

When the Employer purchases the Policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Employer. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.

Your Relationship with Providers and Employers

The relationship between you and any provider is that of provider and patient.

1. You are responsible for choosing your own provider.

2. You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and, for Non-Network Benefits, any amount that exceeds Eligible Expenses. For Covered Health Services from Network providers, you are not responsible for paying any difference between the Eligible Expense and the amount the provider bills.

3. You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

4. You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.

5. You must decide with your provider what care you should receive.

6. Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Employer is that of Employer and Employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Employer, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Employer is responsible for giving notice to you.

Statements by Employer or Subscriber

All statements made by the Employer or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Employer to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

1. bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; and

2. capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We do not pass these rebates on to you nor are they applied to any Annual Deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

1. interpret Benefits under the Policy;

2. interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments; and

3. make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time at our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, at our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

1. Amendments to the Policy are effective 31 days after we send written notice to the Employer;

2. Riders are effective on the date we specify;

3. no agent has the authority to change the Policy or to waive any of its provisions; and

4. no one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our Notice of Information Practices.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Information Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

If you have a work-related Injury or Sickness, and we pay for those medical expenses, we will maintain our right to reimbursement for these payments even though:

1. Workers' Compensation benefits are in dispute or are made by means of a settlement or compromise;

2. no final determination is made that the Injury or Sickness occurred in the course of or resulted from work;

3. the Workers' Compensation insurer and you do not agree on benefits; or

4. there is a dispute as to whether the Injuries were causally related to the job-related incident that is the basis of your claim for Workers' Compensation benefits.

You must notify us of any claim you make to a Workers' Compensation insurer for a work-related Injury or Sickness. You must reimburse us from the Workers' Compensation insurer payment, but only to the extent of any benefits we pay under the plan for the Injury or Sickness.

Reduction in Benefits for Medicare

If you are enrolled in Medicare Part B, we will reduce payment for medical Covered Health Services by the amount that is paid by Medicare.

Subrogation and Right of Reimbursement

You agree that we are subrogated to your rights to damages or recovery from an Injury, Sickness or condition caused by another party, or for which another party is liable, or provides coverage.

For purposes of this section, another party includes, but is not limited to, an insurance carrier providing medical payments, personal injury protection, Workers' Compensation, any other applicable coverage, fault and no-fault, or uninsured or underinsured benefits on behalf of another party.

Our subrogation and recovery rights extend to and include any and all elements of damages or recovery, not just to a recovery for medical expenses. Such rights will not be offset by, nor will we be responsible for, any attorney's fees or costs incurred by you and/or your attorney in obtaining or recovering such damages.

You:

1. must assign to us your claim and right of recovery of all elements of damages against such party, but only up to the amount of the Benefits we pay. You will be deemed to have assigned such claims to us upon our payment of Benefits under the Policy;

2. will not prejudice our subrogation rights, such as entering into a settlement or compromise arrangement with another party without our prior written consent;

3. will promptly advise us in writing whenever you make a claim against another party, or believe another party is responsible for your Injury, Sickness or condition;

4. will provide us with additional information that we reasonably request; and

5. agree to fully cooperate with us in protecting our subrogation rights.

You may receive medical payments from a source other than the plan, including but not limited to, Workers' Compensation, uninsured, underinsured, fault and no-fault auto insurance, or any medical payment or personal injury protection insurance. Your recovery from the other source may be in the form of a settlement, judgment, or other type of payment.

You must reimburse us from such recovery to the extent of the Benefits we pay. We have an automatic lien on such recovery, and we have the right to recover first from any such source of recovery.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

1. all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

2. all or some of the payment we made exceeded the Benefits under the Policy; or

3. all or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Payments made to a provider shall be considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

We may recover from a provider the amount of any part of an overpayment if we initiate the recovery process not later than two years after the payment was made. We shall inform the provider of our determination of overpayment and the provider shall have an opportunity to appeal in the determination. We may initiate recovery of overpayment if:

1. the provider fails to respond within 30 days after notice is given;

2. the provider elects not to appeal the determination; or

3. the provider appeals the determination but the appeal is not upheld.

Notice to the provider of overpayment will be provided in writing and will include:

1. the full name of the Covered Person who received the services for which overpayment was made;

2. the date(s) the services were provided;

3. the amount of the overpayment;

4. the claim number or other pertinent numbers;

5. a detailed explanation of basis for our determination of overpayment;

6. the method in which payment was made including the date of payment and, if applicable, the check number;

7. notification that the provider may appeal the third-party payer's determination of overpayment, if the provider responds to the notice within 30 days; and

8. the method by which recovery of the overpayment would be made, if recovery proceeds.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in Section 6: Questions, Complaints and Appeals. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Employer, including this *Certificate*, the *Schedule of Benefits*, the Employer's application, the Employee's enrollment form, and any Riders and/or Amendments, constitutes the entire Policy.

Certification of Creditable Coverage Forms

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you will be provided with Certification of Creditable Coverage forms if you lost coverage under the Policy on, or after, the effective date of the Policy.

Non-Discrimination

It is our policy (and the policy of our affiliates) to treat all Covered Persons alike, without distinctions based on race, color, religion, national origin, handicap, sex, or age.

Section 9: Defined Terms

Allowable Expense - any necessary, regular, and customary expense, all or part of which is covered by at least one of the plans covering the Covered Person. Allowable Expenses to a Secondary Plan include the value or amount of any deductible amount or coinsurance percentage or amount of otherwise allowable expenses which is not paid by the Primary (first paying) Plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of such service rendered is deemed to be both an Allowable Expenses and a benefit paid.

Alternate Facility - 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:

1. surgical services;

2. Emergency Health Services; or

3. rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services 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 and approved by the [State Department of Insurance]. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per [Calendar][Plan] Year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorder –A condition, marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Calendar Year - January 1 through December 31.

Chiropractic Treatment - the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Claim Determination Period - a period of time during which the Covered Person is covered by the plan.

Coinsurance - the percentage of the cost of Covered Health Services that applies after applicable Copayment and deductible amounts are met. Coinsurance amounts may vary for certain types of Covered Health Services. Coinsurance amounts that we will pay are shown in the *Schedule of Benefits*.

Complications of Pregnancy - a condition that is separate and distinct from the condition of pregnancy and does not include ongoing management of a difficult or high risk pregnancy. Complications of Pregnancy include, but are not limited to:

1. non-elective cesarean section;

2. acute nephritis; nephrosis; cardiac decompensation;

3. missed abortion;

4. ectopic pregnancy that is terminated;

5. spontaneous termination of pregnancy occurring during a term of gestation in which there is not viable birth (this does not include voluntary or elective abortion); and

6. similar medical and surgical conditions of comparable severity.

Complications of Pregnancy do not include:

1. false or premature labor;
2. occasional spotting;
3. Physician prescribed rest during the period of pregnancy;
4. morning sickness;
5. hyperemesis gravidarum; and
6. pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

1. the applicable Copayment; or
2. the Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services that are:

1. incurred while you and your Dependent are insured by the plan;
2. prescribed, ordered, recommended or approved by an authorized health care provider;
3. Medically Necessary;
4. not subject to an applicable limitation or exclusion; and
5. allowed under all other applicable terms and conditions of this *Certificate*, or in a Rider that is attached to this *Certificate*.

We will not pay for that part of a Covered Health Service which:

1. is subject to a Copayment, Annual Deductible, [Per Occurrence Deductible][Per Occurrence Copayment], Coinsurance or penalty; or
2. exceeds an applicable benefit maximum; or
3. is not an Eligible Expense.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care - services that are any of the following:

1. non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating);
2. health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
3. services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

1. a natural child;
2. a stepchild;
3. a legally adopted child;
4. a child placed for adoption; and
5. a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

1. a Dependent includes any child listed above under 26 years of age;
2. a Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Employer is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

1. can withstand repeated use;
2. is not disposable;
3. is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
4. is generally not useful to a person in the absence of a Sickness, Injury or their symptoms;
5. is appropriate for use, and is primarily used, within the home; and
6. is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below.

[Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. The reimbursement amount is based on our predetermined formula. The formula is based on:

1. the type of medical service;
2. the geographic area where the medical service is provided; and
3. other applicable related factors.

We update the formula on a periodic basis.]

[Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, at our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

1. as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);

2. as reported by generally recognized professionals or publications;

3. as used for Medicare; or

4. as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination we accept.]

[Eligible Expenses are the amount we determine that we will consider for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in this *Certificate*.

[For Network Benefits, Eligible Expenses are based on either of the following:

1. when Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider; or

2. when Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated [or authorized by state law].]

[For Non-Network Benefits, Eligible Expenses are based on either of the following:

1. when Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

    a. [for Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

    b. when Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110]% of the amount that the Centers for Medicare and Medicaid Services (CMS) would have paid under the Medicare program for the drug determined by either of the following:

        i. reference to available CMS schedules or

        ii. methods similar to those used by CMS;

    c. fee(s) that are negotiated with the provider;

    d. [50-100]% of the billed charge; or

    e. a fee schedule that we develop;]

[or]

    a. [fee(s) that are negotiated with the provider;

    b. [110]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service [within the geographic market];

    c. [50-100]% of the billed charge; or

    d. a fee schedule that we develop.]

[or]

    a. [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.

    b. If rates have not been negotiated, then one of the following amounts:

        i. [Except for services from the specific providers identified below,] Eligible Expenses are determined based on [110-200]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

ii. [For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,][and] [neonatologist] [and] [consulting Physician] [,] [and] [assistant surgeon] [and] surgical assistant], the Eligible Expense is based on [[110 – 200]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market] [50 – 100]% of the provider's billed charge].]

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

For services other than Pharmaceutical Products, 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 service. The relative value scale currently used is created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. We and OptumInsight are related companies through common ownership by UnitedHealth Group.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale prices for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

c. [When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health Conditions and Substance Use Disorders are based on 80% of the billed charge.]

d. [For Mental Health Conditions and Substance Use Disorders the Eligible Expense will be reduced by [5 – 30]% for Covered Health Services provided by a psychologist and by [5 – 40]% for Covered Health Services provided by a masters level counselor.]

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented with 30 to 90 days after CMS updates its data.

2. When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.]

Eligible Person - an Employee of the Employer or other person whose connection with the Employer meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a medical condition or symptom resulting from and Injury, Sickness or Mental Health Condition that manifests itself by such acute symptoms of sufficient severity, (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency. Emergency Health Services include:

1. a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency medical condition; and

2. such further medical examination and treatment that are required by federal law to stabilize an Emergency medical condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Employee - a person who is being paid a taxable wage or salary by the Employer, and who is eligible for insurance under the Policy.

Employer - your employer who sponsors the plan described in this *Certificate* and includes any subsidiary or affiliate as described in the Employer application.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

1. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;

2. subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational);

3. the subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

1. clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Services;

2. if you are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Services, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

[Hearing Aid – an electronic amplifying device designed to bring sound more effectively into the ear. A Hearing Aid consists of microphone, amplifier and receiver.]

[Hearing Impairment – a reduction in the ability to perceive sound which may range from slight to complete deafness.]

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

1. 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 Physicians; and

2. 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.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily harm or damage to a Covered Person that is the direct result of a covered accident which results in a covered loss independent of Sickness, disease, or bodily infirmity. The Injury must occur while coverage under this Policy is in force as to the Covered Person who sustains the loss.

Inpatient Rehabilitation Facility - 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 authorized by law.

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders 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.

Intermittent Care - skilled nursing care that is provided or needed either:

1. fewer than seven days each week; or

2. fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

1. during the Initial Enrollment Period;

2. during an Open Enrollment Period;

3. during a special enrollment period as described in Section 3: When Coverage Begins; or

4. within 31 days of the date a new Eligible Person first becomes eligible.

Medical Child Support Order - any judgment, decree, or order including approval of a settlement agreement which is made:

1. under a state domestic relations law and requires child support or requires health and/or dental coverage for the child; or

2. by a state agency under a state law for medical child support that is required under the federal Social Security Act.

The Medical Child Support Order must be issued by a court of competent jurisdiction, or issued through a state administrative process, and has the force and effect of law.

Medical Necessity or Medically Necessary - we will determine if a medical service satisfies the following requirements before we will pay any Benefits:

1. must be medically appropriate and consistent to treat an an Injury, Sickness, Mental Health Condition, substance-related and addictive disorders, disease or its symptoms;
2.

3. cannot be excessive in scope, duration or intensity;

4. must be safe, effective and appropriate with regard to accepted standards or medical practice at the time when the medical service is provided;

5. cannot be provided primarily for the comfort or convenience of the Covered Person, a family member or a health care provider;

6. could not be omitted without an adverse affect; and

7. must be the most cost-effective. This means there is not other similar or alternate medical service available at a lower cost.

A final decision to provide medical services can only be made between the Covered Person and the health care provider.

However, we will not pay Benefits if we are not satisfied that a medical service meets all of the above requirements.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Condition - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless the Mental Health Condition is specifically excluded under the Policy.

For purposes of this definition, a Mental Health Condition does not include Substance Use Disorders.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Health Conditions. 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 Health Service.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the [Shared Savings Program]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you may pay every [Calendar][Plan] Year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

[Per Occurrence Deductible][Per Occurrence Copayment] - for Benefit plans that have a [Per Occurrence Deductible] [Per Occurrence Copayment], this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services [prior to and in addition to any Annual Deductible] before we will begin paying for Benefits for those Covered Health Services. The [Per Occurrence Deductible][Per Occurrence Copayment] does not apply to the Annual Deductible or the Out-of-Pocket Maximum.

When a Benefit plan has a [Per Occurrence Deductible][Per Occurrence Copayment], you are responsible for paying the lesser of the following:

1. the applicable [Per Occurrence Deductible][Per Occurrence Copayment]; or

2. the Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a [Per Occurrence Deductible][Per Occurrence Copayment] and for details about the specific Covered Health Services to which the [Per Occurrence Deductible][Per Occurrence Copayment] applies.

Pharmaceutical Product(s) - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Plan - any plan providing benefits or services for or by reason of hospital, medical or dental care or treatment which benefits or services are provided by:

1. group or blanket insurance or coverage;

2. group Blue Cross, Blue Shield or other prepayment coverage provided on a group basis;

3. any coverage under labor management trusteed plans, union welfare plans, employer organizational plans, employee benefit organization plans, or other uninsured arrangement of group or group-type coverage;

4. any coverage required or provided by any statute, except Medicare, Medicaid, or any plan when, by law, its benefits are excess to This Plan coverage;

5. any group or group-type coverage through HMOs and other prepayment group practice and individual practice plans; or

6. any fault or no-fault automobile insurance.

This term means policy, contract, or other arrangement which reserves the right to take the benefits or services provided by other plans into consideration to determine its benefits.

[Plan Year - the period of 12 consecutive months beginning on your effective date under this Policy and each successive period of 12 consecutive months thereafter.]

Policy - the entire agreement issued to the Employer that includes all of the following:

1. the *Group Policy*;

2. this *Certificate*;

3. the *Schedule of Benefits*;

4. the Employer's application;

5. the Employee enrollment form;

6. Riders; and

7. Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

1. prenatal care;

2. postnatal care; and

3. childbirth.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Primary Plan - the plan which determines its benefits before those of the other Plan and without considering the other Plan's benefits.

Qualified - the Medical Child Support Order:

1. creates or recognizes the child's right to receive health and/or dental coverage;

2. includes the required name and last known mailing address of the child and a reasonable description of the coverage to be provided;

3. includes the time period to which the Medical Child Support Order applies; and

4. does not require a type of coverage not otherwise provided by the plan, except as necessary under applicable law.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by us.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- 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 Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. [(Note that Benefits for outpatient Prescription Drugs[,] [Pediatric Vision Care Services] [and] [Pediatric Dental Services], while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.] 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.

Secondary Plan - the plan which determines its benefits after those of the other Plan. The benefits of the Secondary Plan may be reduced because of the other Plan's benefits.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health 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.

[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - disorder, dysfunction, or illness of the body.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Employer.

Substance Use Disorder - abuse of, addiction to or unlawful use of drugs, toxic inhalants or illegal or controlled substances. Substance does not include tobacco, nicotine or food.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services 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 Health Service.

Terminally ill - a Physician has given a prognosis that a Covered Person has six months or less to live.

This Plan - refers to provisions of the Policy which are subject to Section 7: Coordination of Benefits.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

1. Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

2. Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. [You can view these policies at [www.myallsavers.com].]

Please note:

1. if you have a life-threatening Sickness or condition (one that is likely to cause death within two years of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health;

2. we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

    a. if the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved;

    b. it must be performed by a Physician and in a facility with demonstrated experience and expertise;

    c. the Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective;

    d. at least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven; and

    e. the service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but Unproven Services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.