US Health and Life Insurance Company
d/b/a Ascension Personalized Care (APC)
Home Office: 8220 Irving Road, Sterling Heights, Michigan 48312

INDIVIDUAL EPO MEDICAL POLICY

Policy No.:[XXX-XXX-XXX] Total Premium [$XXXX.XX]

Policyholder: [John Doe] Effective Date: [Month Day, Year]

This contract describes the benefits provided by US Health and Life Insurance Company and the exclusions and limitations. This contract is guaranteed to be renewable by the Insured and cannot be cancelled by Us except for specified situations described in this contract.

This contract begins at 12:01 a.m. at the place of your residence on the date this coverage becomes effective for the Insured. It ends, subject to the grace period, at 12:01 a.m. at the place of your residence on the last day the Insured is entitled to coverage under the terms of this contract.

10-Day Right to Examine and Return this Policy
If you are not satisfied you have the right to return this Plan within 10 days of delivery to you for a full refund of any Premium paid.

Important Notice
Exclusive Provider Organization (EPO) plans cover health care services only when provided by a doctor or facility who participates in the network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all the costs for the services, except that emergency services must be covered regardless of whether they are delivered by a participating provider.

US Health and Life Insurance Company is a Qualified Health Plan issuer in the Federal Health Insurance Marketplace.

This Policy is signed for us as of the Effective Date as shown above.

[Officer's Signature]

[Officer's Title]

NOTICE

The Policy contains Utilization Management requirements. Prior Authorization is required for all inpatient admissions to Acute Care Hospitals and other facilities unless the admission is for an emergency service, a life-threatening condition, for obstetrical care or occurs outside the 50 United States. Prior Authorization is also required for certain other services. Please refer to the Utilization Management section for the list of services and treatments for which Prior Authorization is required.

Admission certification is required within 48 hours following all emergency admissions.

Failure to comply with Utilization Management requirements may result in a reduction of benefit reimbursement as described herein.

Prior Authorization Review may be obtained by contacting the Utilization Management company listed on Insured's Identification Card. The Utilization Management phone number is [(1-800-856-3775)].

Prior Authorization Review does not guarantee reimbursement under the Policy. Reimbursement is subject to eligibility and benefit coverage at the time of service and is subject to all the terms, conditions and limitations of the Policy.

Women's Health Care and Cancer Rights Act (WHCRA) Notice

US Health and Life Insurance Company is notifying you of the following coverage mandated by state and federal law. When the need for such benefits is determined by the Insured and the Insured's attending physician, benefits include the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of all stages of mastectomy, including lymphedemas.

Normal Deductible, Coinsurance or Copayment amounts applicable to Your health coverage are also applicable to these benefits.

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SECTION 1. GENERAL DEFINITIONS

In this Policy, the Policyholder may be referred to as “you”, your”, or “yours”. US Health and Life Insurance Company will be referred to as "we", "our", "us" or the “Company”.

Certain words and/or phrases that are used and capitalized throughout the Policy are defined and explained below. These definitions and/or explanations shall control with respect to the interpretation of the Company.

Masculine pronouns used in this Policy shall include masculine or feminine gender unless the context indicates otherwise.

"Acute Care Hospital" means an institution which is licensed as such by duly constituted state authority and which maintains an operating room equipped to handle surgical procedures, is staffed always with one or more Physicians and one or more Registered Nurses (R.N.) for patients admitted for a variety of medical conditions. It is not, other than incidentally, a place for rest, a place for the aged, a place for the treatment of Substance Abuse, a place for alcoholics, or a nursing or convalescent home.

"Ambulatory Care Center" means a specialized facility:

A. where coverage in such facility is mandated by law, which has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or

B. where coverage in such facility is not mandated by law, which meets all the following requirements:

1) it is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures; and
2) it is operated under the supervision of a licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Acute Care Hospital in the area; and
3) it requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure; and
4) it provides at least 2 operating rooms and at least one post-anesthesia recovery room; to be equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply; and

5) it provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room; and

6) it maintains a written agreement with at least one Acute Care Hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement; and

7) it maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under

local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report, and a discharge summary.

“Approved Clinical Trial” means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either:

A. a federally funded or approved study or investigation; or

B. a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

C. a study or investigation that is a drug trial exempt from having such an investigational new drug application.

“Assisted Living Facility” means a facility designed to provide residents only with assistance with basic ADLs (activities of daily living) such as bathing, grooming, dressing, and more.

“Autism Spectrum Disorder” means a neurological condition, including Asperger’s syndrome and autism, as defined in the Diagnostic and Statistical Manual of Mental Disorders.

"Birthing Center" means a facility operated by an Acute Care Hospital or other licensed health care institution for the purposes of providing facilities for childbirth as an alternative to the environment of the Acute Care Hospital delivery room.

“Brand Name Drug” means a Prescription Drug that has no Generic Drug equivalent or a Prescription Drug that is the innovator or original formulation for which a Generic Drug equivalent exists.

"Cardiac Rehabilitation" means the method by which an individual is restored to his best physical, medical, and psychological status after a cardiac event or diagnosis of cardiac dysfunction. Cardiac Rehabilitation is divided into three phases: Phase I begins during Inpatient hospitalization and is managed by the patient's Physician; Phase II is a medically supervised Outpatient program that begins following discharge from an Inpatient hospitalization; and Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic follow-up. Each phase includes an exercise component, patient education, and risk factor modification.

“Class” means the drug class assigned by the national drug classification (NDC) system.

"Copay" means a service specific deductible expressed as a flat dollar amount and payable by an Insured at the place and time services are rendered. This amount is not part of the Deductible.

"Coinsurance” means the sharing of the cost of Covered Expenses between the Company and the Insured. When the Company pays a percentage of the Reasonable and Customary Charge or the Exclusive Provider Organization's approved fee, the Coinsurance equals the Insured's balance.

"Confinement" or "Confined" means admitted as an Inpatient.

"Cosmetic Surgery" means reconstructive or plastic surgery which is done primarily to improve the physical appearance of the patient and which improves the physical appearance but does not correct or improve a medical condition.

"Covered Expenses" means the costs incurred with respect to the services, supplies, and charges for which benefits are provided in the Policy, and as more specifically defined in the provisions of the Policy relating to coverage.

"Custodial Care" means care given mainly to help a person with daily living activities, and not primarily given to assist such person in recovering from an Injury or Illness. This type of care will be considered custodial regardless of whether or not the patient is under a Physician's care and/or the Custodial Care is requested by the Physician.

The provision of Custodial Care by trained medical personnel, such as a Physician, licensed nurse or registered therapist, does not cause the services to be classified as skilled services. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services will be considered Custodial Care. Care of ventilator patients whose condition is stable, unlikely to change, or does not require constant re-evaluation and clinical intervention shall be deemed as Custodial Care.

“Custodial Care Facility” means a facility that provides personal care including assistance with “activities of daily living" such as bathing, dressing, eating, going to the bathroom, moving around and getting into and out of bed.

"Deductible" means the amount of Covered Expenses that an individual and/or family must satisfy before being eligible for certain benefits to be payable by the Company.

“Individual Deductible” shall mean the amount of Covered Expenses that an Individual must satisfy within a Plan Year, before eligible for certain benefits to be payable by the Company.

“Aggregate Family Deductible” shall mean the amount of Covered Expenses that a Family must cumulatively satisfy, within a Plan Year, before the Deductible shall be deemed satisfied for all members of the Family. No Family member shall be entitled to benefits before the Family incurs Covered Expenses in an amount at least equal to the Family deductible.

"Dentist" means a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

["Dependent" includes your legal spouse or your child(ren). The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom you have been awarded legal guardianship.
- A child for which there is a Qualified Medical Child Support Order requiring coverage.

Your newborn child(ren) and newborn adopted child(ren) are covered from the moment of birth. In order to continue coverage beyond the first 31 days following the moment of birth, we will require notice within the 31-day period and payment of the required premium.

Stepchildren and children under court appointed guardianship are eligible from the date the child becomes a stepchild or the date you are appointed guardian by the court. Adopted children are eligible from the earlier of the date the child is placed with you for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

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

- A Dependent includes any child listed above, through the last day of the year in which they turn 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes physically or mentally incapable of self-support. We have the right to require proof of incapacity within 31 days after coverage would otherwise terminate, and proof once each year after that of the continuation of the incapacity.]

“Dispensed as Written (DAW)” means:

DAW 1: when the Physician prescribes the Brand Name Drug because of specific medical reason the Insured will be charged the appropriate Brand Name Drug Copay.

DAW 2: when the Insured requests the Brand Name Drug instead of the available Generic Drug the Insured will be charged the Brand Name Drug Copay PLUS the difference in cost between the Generic Drug and the requested Brand Name Drug.

"Emergency Dental Treatment" means dental care necessary because of a condition that is life-threatening or threatening to the vitality of a tooth or teeth, that has a sudden onset and demands prompt, when treatment begins within 30 days of the accident.

“Emergency Admission” means an admission to the hospital as a registered bed patient directly from the emergency room of the hospital.

“Emergency Medical Condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention where the absence of immediate medical attention may result in any of the following:

A. 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; or

B. serious impairment to bodily functions; or

C. serious dysfunction of any bodily organ or part; or

D. with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

“Emergency Services” means with respect to an emergency medical condition, a medical screening examination that is:

A. within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

B. within the capabilities of the staff and facilities available at the hospital when such further medical examination and treatment are required to stabilize the patient.

“Essential Health Benefits” means benefits covered under the Policy, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

"Expenses Incurred" means a charge, which shall be deemed to be incurred on the day the purchase is made, or on the day the service is rendered for which a charge is made.

"Experimental or Investigational" means a service, supply or treatment that is deemed experimental or investigational by any technological assessment body established by any state or federal government; or meets one or more of these conditions:

A. it is within the research, investigational or experimental stage;

B. it involves the use of a drug or substance that has not been approved by the United States Food and Drug Administration by the issuance of a New Drug Application or other formal approval, or has been labeled "Caution: Limited by Federal Law to Investigational Use";

C. it is not of general use by qualified Physicians;

D. it is not of demonstrated value for the diagnosis or treatment of an Illness or Injury; or

E. the drug or device cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.

F. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

G. reliable evidence shows that the drug, device medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

H. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence includes anything determined to be such by the Company within the exercise of its discretion. It includes published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; and written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

Routine Care Costs incurred in the course of a clinical trial, that would be otherwise covered if not incurred in the course of a clinical trial, are not considered experimental/investigational costs. Routine Care Costs do not include:

1. the health care service, item, or investigational drug that is the subject of the clinical trial.

2. any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.

3. any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.

4. an investigational drug or device that has not been approved for market by the federal Food and Drug Administration.

5. transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.

6. a service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.

7. a service, item, or drug that is eligible for reimbursement from a source other than a covered individual's policy of accident and sickness insurance, including the sponsor of the clinical trial.

“FDA” means the United States Food and Drug Administration.

“Formulary” means a list of drugs that has been developed, organized and is administered to promote rational, clinically appropriate, safe and cost-effective drug therapy.

“Generic Drug” means a Prescription Drug that is medically equivalent to a Brand Name Drug as determined by the FDA. It meets the same standards as a Brand Name Drug for purity, safety, strength and effectiveness and is manufactured and sold under its chemical, common, or official name.

"HIPAA" means Health Insurance Portability and Accountability Act of 1996 and used to refer to the rights provided under the Act, in addition to those expressly authorized by the Company.

"Home Health Agency" means only a public agency or private organization, or a subdivision of such an agency or organization, that is: primarily engaged in providing skilled nursing services and other therapeutic services; has policies established by a group of professional personnel employed with the agency or organization, including one or more legally qualified Physicians and one or more Registered Nurses (R.N.); maintains clinical records on all patients; and, in the case of an agency or organization in any state in which state or applicable local law provides for licensing of agencies or organizations of this nature, is licensed under such law or is approved by the agency of such state or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing. The term "Home Health Agency" does not include any agency or organization or subdivision which is engaged primarily in the care and treatment of a mental disease.

"Hospice Care Program" means a program that provides palliative and supportive care for terminally ill patients and their families and that is organized and licensed as such by the state in which it is headquartered. If accreditation is available, the program must have been currently accredited. In the event that state laws or regulations do not exist with respect to Hospice Care Programs, the program must be accredited by a national accrediting organization or be recognized as a Hospice Care Program or a demonstration Hospice Care Program by the U.S. Department of Health and Human Services. Hospice care can be provided at home, in a hospice, in a Skilled Nursing Facility, in an Acute Care Hospital, or in another freestanding facility.

"Hospital Charges" means only the following Covered Expenses:

A. charges made by an Acute Care Hospital for room and board;

B. charges made by the Acute Care Hospital for other Acute Care Hospital services and supplies furnished to an Insured for his use while he is confined (but not including charges for special nursing services or services of Physicians); and

C. charges for anesthetics and their administration when incurred during a Confinement in an Acute Care Hospital.

"Illegal Occupation" means the Company shall not be liable for any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured's being engaged in an illegal occupation.

"Illness" means only sickness or disease including mental infirmity, which requires treatment by a Physician. For purposes of determining benefits payable, "Illness" shall include Pregnancy. All related Illnesses shall be considered one Illness. Concurrent Illnesses shall also be considered one Illness unless such Illnesses are clearly unrelated.

"Injury" means only bodily Injury sustained accidentally by external means, including such Illness as results from an accident. All Injuries sustained by an Insured in connection with any accident shall be considered one Injury.

“In-Network Provider” means those Physicians or facilities that have contracted to participate in the Exclusive Provider Organizations chosen by the Company.

“Inpatient" means a person who is Confined.

“Inpatient Rehabilitation Facility” means Physical Rehabilitation Units that are licensed special care units (or freestanding facilities) that provide intensive rehabilitation services through a multi-disciplinary coordinated team approach. The rehabilitation program for each patient includes:

A. medical supervision by a physician with specialized training or experience in rehabilitation (i.e., 24-hour physician availability, with physician evaluation of the patient at least 3 times a week);

B. 24-hour rehabilitation nursing (i.e., 24-hour availability of a registered nurse with specialized training or experience in rehabilitation);

C. social services; and physical therapy and/or occupational therapy for at least 3 hours per day five days a week;

D. speech-language pathology services and/or psychological services.

“Insured” means the person named on the Identification Card. Insured also means the following persons that have been duly enrolled in the Company's records according to the specifications set forth in the Enrollment and Effective Dates section:

1. The spouse of the Insured; and
2. Each Dependent (as defined in this Policy) of the Insured.

Insured does not refer to persons who have been voluntarily disenrolled by the person named on the Identification Card.

"Intensive Care Unit" means a special unit in an Acute Care Hospital concentrating all necessary types of equipment together with skilled nursing. This shall include coronary care, burn unit, and intensive isolation.

"Intermediate Care" means the use, in a full (24-hour) residential therapy setting, or in a partial (less than 24-hour) residential therapy setting, of any or all of the following therapeutic techniques, as identified in a

treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

A. counseling; or

B. detoxification services; or

C. other ancillary services such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan; or

D. chemotherapy.

“Long Term Acute Care Facility” means a facility which is licensed as such by a duly constituted state authority and provides care for patients who are deemed stable to be discharged from an acute care hospital but who require intensive services such as complicated IV therapy, complicated wound care or other therapy not appropriate to be provided in a Skilled Nursing Facility.

“Mail Order” means only Prescription Drugs that are dispensed by the prescription drug program vendor listed on your identification card, or its contracted Mail Order pharmacy. Mail Order can include use of the United States Post Office or similar delivery services. Similar services by your local pharmacy do not qualify for the Mail Order Copay. Mail Order drugs are dispensed in up to 90-day quantities.

"Medical Charges" means Covered Expenses that are not Hospital charges or Surgical Charges.

“Medical Literature” means two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed. However, if two other articles from major peer-reviewed medical journals have concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug’s safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed, none of the articles shall be used to meet the requirement listed above. Peer reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or a health carrier.

“Medically Appropriate” means services or supplies, which the Company determines, in the exercise of its discretion, are performed or provided according to generally professionally accepted standards of medical practice for the condition being treated.

“Medically Necessary"/”Medical Necessity” means services or supplies which the Company determines, in the exercise of its discretion, are generally professionally accepted as the usual, customary, and effective means of treating the sickness or injury in the United States and required to diagnose or treat a Covered Illness or Injury, consistent with the symptoms of the diagnosis. Services and supplies that are:

A. safe, effective, and appropriate with regard to standards of good medical practice; and

B. customarily applied in the care of persons with similar complaints and findings by similarly trained practitioners or providers; and

C. generally accepted as the effective elements of care; and

D. not solely for the convenience of the patient or the provider; and

E. approved by regulatory authorities such as the Food and Drug Administration; and

F. the most appropriate supply or level of service which can be safely provided to the patient.

When applied to the care of an inpatient, this means that the medical symptoms or condition require that the services cannot be safely provided to the patient as an outpatient.

The fact that a physician or health care provider has prescribed, ordered, or recommended a service or supply does not in itself mean that it is Medically Necessary as defined.

"Medicare" means the programs established by Title 1 of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act, and which includes Part A--Hospital Insurance Benefits for the Aged, and Part B--Supplementary Medical Insurance Benefits for the Aged.

“Mental Illness” means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (hypomanic, manic, depressive, and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizoaffective disorders (bipolar or depressive);
6. autism spectrum disorders*;
7. obsessive-compulsive disorders;
8. depression in childhood and adolescence;
9. panic disorder; and
10. post-traumatic stress disorders (acute, chronic, or with delayed onset).

*Autism Spectrum Disorders are covered under the Autism Spectrum Disorders Benefit and not the general benefits for Mental Illness.

"Network" shall refer to those Physicians and facilities that have contracted to participate in the Exclusive Provider Organizations chosen by the Company. "In-Network" shall refer to services received through providers that participate in the Network, while "Out-of-Network" shall refer to services received through non-participating providers.

“New Drug” means a drug that is approved by the FDA after the date of this coverage. If these drugs fall into a covered class of drugs they will be subject to Prior Authorization for at least 90 days. If these drugs fall into an excluded class of drugs, they will be excluded from coverage.

“Non-occupational" means, with respect to Injury, an Injury which does not arise out of and in the course of any employment for wage or profit; and, with respect to Illness, means a disease in connection with which the person is entitled to no benefits under any Workers' Compensation law or similar legislation.

“Observation Status” means that a person is undergoing Outpatient short-term treatment and testing while a decision is made whether to intensify or cancel clinical services depending on the severity of the presenting factors. If more intense treatment is deemed medically appropriate and medically necessary, the person is admitted as an inpatient. If not, the person is discharged.

"Out-of-Network Provider" shall refer to Physicians and facilities that have not contracted to participate in the Exclusive Provider Organizations chosen by the Company.

“Outpatient" means a person who is not Confined.

“Outpatient Treatment” means treatment of a person who is not Confined.

“Partial Hospital Program” means an approved or licensed program when provided at a facility that provides psychiatric service for the diagnosis and treatment of Mental Illness for patients who do not require full time hospitalization but who need broader programs than are possible from outpatient visits. Care is provided by or under the supervision of a licensed Physician and other appropriate licensed medical staff (e.g. RN, MSW, Psychologist).

“Participating Pharmacy” means a pharmacy that has entered into a prescription drug plan agreement with the Pharmacy Benefit Manager listed on your identification card.

“Patient Protection And Affordable Care Act Of 2010” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“Pharmacy Benefit Manager (PBM)” means the prescription drug program vendor listed on your identification card.

"Physician" means a medical practitioner who is acting within the lawful scope of his license and includes the following:

- Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN);
- Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:
  - Licensed Clinical Marriage and Family Therapist (LCMFT);
  - Licensed Clinical Professional Counselor (LCPC);
  - Licensed Clinical Psychotherapist (LCP);
  - Licensed Specialist Clinical Social Worker (LSCSW);
- Audiologist;
- Certified Diabetic Educator/Licensed Dietitian (for covered diabetic education services);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Licensed Physical Therapist (LPT);
- Occupational Therapist;
- Doctor of Optometry (OD);
- Oral Surgeon;
- Physician Assistant (PA);
- Doctor of Podiatric Medicine (DPM);
- Psychologist licensed to practice under the laws of the state in which covered services are received; and
- Speech-Language Pathologist.

Physician or Doctor, as defined above, shall not include the insured individual or his dependents or any person who is the spouse, parent, child, brother or sister of such insured individual or his dependents.

For purposes of determining the copay to be applied, the following terms apply:

Primary Care Physician or Doctor shall mean a Physician or Doctor who may provide the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. This Physician or Doctor generally does not specialize in any medical specialty except in the case of a gynecologist for the care of women and family practice, general practice, pediatrics, and internal medicine.

Specialist Physician or Doctor shall mean a Physician or doctor who engages in a medical specialty other than gynecology, family practice, general practice, pediatrics, and internal medicine.

“Plan Year” means the period beginning on the effective date of the Policy and continuing for 12 months and each subsequent 12-month renewal period.

"Podiatric Care" means treatment of the foot and its related parts, such as ankles, toes, heels, etc., including surgery, orthotics, debridement, x-rays and other care prescribed by a Physician.

“Policy, The Policy, This Policy” means the entire agreement that includes all the following:

- This Policy
- The Schedule of Benefits.
- [Riders.
- Amendments.]

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

“Policyholder” means the person (who is not a Dependent) to whom this Policy is issued.

"Pre-admission Testing" means Outpatient diagnostic tests performed on an Insured during the 10- day period before being admitted as an Inpatient; or within 48 hours before an Outpatient surgical admission at an Acute Care Hospital. The time requirement will be waived if:

A. medical complications delay the intended Surgical Procedure; or

B. the Confinement is cancelled or postponed because a bed is unavailable; or

C. there is a change in the Insured's condition that precludes the Surgical Procedure.

"Pregnancy" means the state in which a woman carries a fertilized egg inside her body. For the purposes of this policy, it also includes spontaneous abortion, miscarriage, childbirth, and complications arising during Pregnancy.

“Prescription Drug” means a drug that is available only by Prescription Order.

“Prescription Order” means the written or oral authorization of a Prescription Drug by a Physician who is licensed to make such authorization in the ordinary course of his professional practice.

"Psychiatric care" means evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

“Psychiatric Facility” means a special care unit or freestanding facility that is licensed as such by duly constituted state authority and that provides psychiatric service for the diagnosis and treatment of Mental Illness on a 24 hour basis by or under the supervision of a licensed physician and other appropriate licensed medical staff (e.g. RN, MSW, Psychologist).

"Psychiatric Treatment" means treatment care for a mental disease or disorder or a functional nervous disorder.

"Psychological care" means evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

“Qualified Individual” means an Insured who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either:

A. the referring health care professional is an In-Network health care provider and has concluded that the individual’s participation in the trial would be appropriate; or

B. the Insured provides medical or scientific information establishing that the Insured’s participation in the trial would be appropriate.

“Qualified Health Plan Issuer” means a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from [Name of Exchange].

“Qualified Medical Child Support Order” (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of Alternate Recipient's right to or assigns to an Alternate Recipient the right to receive benefits for which a Covered Individual or eligible Dependent is entitled under this Policy.

In order for such an order to be a QMCSO, it must clearly specify:

A. the name and last known mailing address (if any) of the Policyholder and the name and mailing address of each such Alternate Recipient covered by the order;

B. a reasonable description of the type of coverage to be provided by the Policy to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

C. the period of coverage to which the order pertains; and

D. the name of this Policy.

However, such an order need not be recognized as "qualified" if it requires the Policy to provide any type or form of benefit, or any option not otherwise provided to Insureds without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders as described in Social Security Act 1908 (as added by Omnibus Budget Reconciliation Act of 1993 § 13822).

"Reasonable and Customary Charge" See “Usual, Customary and Reasonable”.

"Related Confinement" means any confinement unless:

A. the subsequent confinement is due to causes entirely unrelated to the causes of the previous confinement; or

B. the confinements are separated by a continuous period of at least 2 weeks;

“Residential Psychiatric Facility” means a long term live in facility for the treatment of mental illness.

“Residential Substance Abuse Facility” means a long term live in facility for the treatment of substance abuse.

“Routine Patient Care Costs” mean all items and services consistent with the coverage provided in this policy that are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. Routine Patient Care Costs do not include:

A. the health care service, item, or investigational drug that is the subject of the clinical trial;

B. any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial;

C. any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient;

D. an investigational drug or device that has not been approved for market by the federal Food and Drug Administration;

E. transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted;

F. a service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient; or

G. a service, item, or drug that is eligible for reimbursement from a source other than a covered individual's policy of accident and sickness insurance, including the sponsor of the clinical trial.

“Semi-Private Room and Board” means a 2-bed room accommodation.

“Significant Break in Coverage” means a lapse of coverage of more than 62 consecutive days. A Waiting Period shall not be considered a part of a Significant Break in Coverage.

"Skilled Nursing Facility" means an institution (or a distinct part of an institution) which:

A. is primarily engaged in providing for Inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;

B. has policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more Registered Nurses, to govern the skilled nursing care and related medical or other services it provides;

C. has a Physician, a Registered Nurse, or a medical staff responsible for the execution of such policies;

D. has a requirement that the health care of every patient must be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency;

E. maintains clinical records on all patients;

F. provides 24-hour nursing care in accordance with the policies developed as provided in subparagraph B. above, and has at least one Registered Nurse employed full-time;

G. provides appropriate methods and procedures for dispensing and administering drugs and biologicals;

H. has in place a utilization review plan which provides for the review, on a sample or other basis, of admissions to the institution, the duration of stays, and the professional services (including drugs and biologicals) furnished with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services and with such review to be made by either a staff committee of the institution composed of 2 or more Physicians, with or without participation of other professional personnel, or a group similarly composed which is established by the local medical society and some or all of the Acute Care Hospitals and Skilled Nursing Facilities in the locality. Such review provides for prompt notification to the facility, the individual, and the attending Physician of a finding that further stay in the facility is not Medically Necessary;

I. is licensed under the applicable state or local law or is approved by the appropriate state or local agency for such licensing, except that such term shall not include any institution which is primarily used for Custodial Care.

“Specialty Drugs” means biotechnical drugs that are oral, injectable, infused or inhaled medications that are either self-administered or administered by a health care provider and used or obtained in either an outpatient or home setting.

"Spinal Manipulative Services/Chiropractic Treatment" means treatment of the musculoskeletal system through sublimation, manipulation or other similar treatments including medical diagnostic testing to determine necessity of treatment prescribed by a Physician.

“Stabilize” means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

“Standard Reference Compendia” includes the American Hospital Formulary Service-Drug Information or the United States Pharmacopoeia-Drug Information.

“Substance Abuse” means the taking of alcohol or other drugs at dosages that place an individual’s social, economic, psychological, and physical welfare in potential hazard. “Substance Abuse” shall also be understood to apply to an individual who loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare.

“Substance Abuse Facility” means a special care unit or freestanding facility that is licensed as such by duly constituted state authority and that provides detox services for the diagnosis and treatment of substance abuse on a 24 hour basis by or under the supervision of a licensed Physician and other appropriate licensed medical staff (e.g. RN, MSW, Psychologist).

“Surgical Charges” means the Covered Expenses incurred for the professional services of the operating Physician in performing a Surgical Procedure or procedures on an Insured, including usual, necessary, and related preoperative and postoperative treatment in connection with the Surgical Procedure.

“Surgical Procedure” means a procedure defined as such in the most current version of the Current Procedural Terminology (CPT) or the most current version of the International Classification of Diseases, Clinical Modification (ICD-9-CM or ICD-10-CM).

“Telemedicine” means the use of an electronic media to link Insureds with Physicians in different locations. To be considered Telemedicine, the Physician must be able to examine the Insured via a HIPAA-compliance real-time, interactive audio or video, or both, telecommunications system, or store and

forward online messaging, and the Insured must be able to interact with the off-site Physician at the time the services are provided. Telemedicine includes Telepsychiatry.

"Temporomandibular Joint (TMJ) and Comparable Disorders" includes temporomandibular, craniomandibular, head and neck neuromuscular or similar disorders.

"Totally Disabled" means that the Insured:

A. is prevented, solely because of a Non-occupational Injury or Non- occupational Illness, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit.

B. if a Dependent, is prevented, solely because of a Non-occupational Injury or Non-occupational Illness, from engaging in all of the normal activities of a person of like age and sex who is in good health.

"Treatment" means medical care or attention, providing services or medication, consultations, testing.

“Unbundling” means the practice of coding the individual components of a procedure when only a single code is generally utilized to describe the service or is appropriate under guidelines in the National Correct Coding Initiative Policy Manual.

“Urgent Admission” means an admission to the hospital as a registered bed patient directly from the physician's office.

“Urgent Care Center” means a facility, not including a hospital emergency room for a physician’s office, that provides treatment or services that are required:

1. To prevent serious deterioration of an Insured’s health; and
2. As a result of an unforeseen illness, injury, or the onset of acute or severe symptoms.

“Usual, Customary And Reasonable Charges” means the following: The payment of benefits is based on the most frequently charged fees by providers in the same geographical locality for a comparable service or supply. For out-of-network services, charges are screened against commercial databases consisting of aggregated data collected from all health plan payers or other normative data derived from sources such as Medicare cost to charge ratios, average wholesale price data for prescriptions, and/or manufacturer’s retail pricing for certain supplies and devices. This data is updated at least every 6 months. If you use a non-network provider, you will be responsible for all amounts in excess of Usual, Customary and Reasonable Charges and these amounts may be substantial. For out-of-network professional services (service provided by an individual practitioner), Usual, Customary and Reasonable Charges shall mean that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered.

“Workers’ Compensation” means any federal or state benefits program provided for any bodily injury or bodily sickness arising out of and in the course of employment.

"Written Notice" means notice in writing on a form supplied by or satisfactory to the Company.

SECTION 2. PREMIUMS; ENROLLMENT; EFFECTIVE DATE

Payment of Premiums

1. The premiums for this contract are due and payable as follows:
    a. Initial premiums -- In advance of the date this coverage becomes effective for you
    b. Subsequent premiums -- On the first day of each subsequent payment period

2. Nonpayment of premiums occurs when:
    a. Premiums are not paid by the due dates as provided in 1. above; and/or
    b. Premiums are not paid by you, your relative by blood, marriage or adoption, or an organization specifically designated by federal or state law as an entity from whom the Company must accept premiums.

Payment of premiums is subject to the grace periods listed in Section 3. Cancellation.

Enrollment and Effective Date

In order to enroll or make a change due to any of the events listed below, a qualified individual or Insured must notify the Company within 60 days of a triggering event. This may require the submission of a change form. The addition of new Insureds due to one of these triggering events may require a change in coverage type and/or additional premiums. All notifications of triggering events for an Exchange Plan must be submitted to the Exchange.

A. Open Enrollment

Qualified individuals and Insureds may enroll in or change from one QHP to another during annual open enrollment periods established by Health and Human Services. Effective dates are also established by Health and Human Services.

1. Effective Dates for All Other Special Enrollment Events

    a. If notification of a change to your enrollment is received by the Company between the first and the fifteenth day of any month, such change will be effective on the first day of the following month.

    b. If notification of a change to your enrollment is received by the Company between the sixteenth and the last day of any month, such change will be effective on the first day of the second following month.

B. Special Enrollment

Triggering Events Effective on the First of the Month Following the Event

1. Qualified individuals may enroll in your Qualified Health Plan (QHP) or a QHP of their choosing as a result of the following triggering event:

    a. Adding a dependent or becoming a dependent through marriage. Applicable to the employee, spouse, and any newly-acquired Dependent(s) only.

    Note: The Insured may not change their current QHP due to adding a Dependent.

2. Qualified individuals and Insureds may enroll in or change from one Qualified Health Plan (QHP) to another as a result of the following triggering events:

    a. Loss of minimum essential coverage

    b. Adding a Dependent or becoming a Dependent through marriage

c. Gaining access to new QHPs as a result of a permanent change of address. You must have minimum essential coverage for one or more days in the 60 days prior to the move unless moving from a foreign country or a United States territory.

d. Enrollment or non-enrollment in a QHP is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace (Exchange) or Health and Human Services or its instrumentalities as evaluated and determined by the Exchange.

e. A QHP enrollee adequately demonstrates to the Exchange the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to that enrollee.

f. Becoming newly eligible for advance premium tax credits or cost sharing reductions.

g. An individual enrolled in any non-calendar year group health plan or individual health insurance coverage will qualify for Special Enrollment, even if the qualified individual or his or her dependent has the option to renew such coverage.

h. An individual, who was not previously a citizen, national or lawfully present individual gains such status.

i. An Indian may enroll in a QHP or change from one QHP to another one time per month.

j. Meeting other exceptional circumstances as the Exchange may provide.

Triggering Events Effective on the Date of the Event

1. Adding a Dependent through birth, adoption or placement for adoption

a. Advance premium tax credits and cost sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

b. If the current coverage provides benefits for only the parent(s) of the newborn child, coverage must be changed to a type which provides benefits for dependent children within 60 days of a triggering event, in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour period.

Covered services received by the child within the initial 48 or 96 hour period will be treated as though they were services received by the parent Insured.

c. A newborn, an adopted child (including a newborn) from the date the petition for adoption was filed, or a child placed in the Insured's home by a child placement agency, as defined by state law for the purpose of adoption, is covered as follows, if the type of coverage is for two or more Insureds. Coverage is effective and provided without charge for 31 days beginning on the date of birth for:

(1) natural newborns

(2) newborns for which the petition for adoption has been filed within 31 days following birth

Exception: If the petition of adoption is filed after 31 days of birth, coverage will be effective the date the petition for adoption was filed and provided without charge for 31 days.

(3) newborns placed in the Insured's home within 31 days following birth

Exception: If a child is placed after 31 days of birth, coverage will be effective the date of placement and provided without charge for 31 days.

d. Coverage for family members includes delivery and obstetrical expenses at birth for the birth mother of a child adopted by the Insured within 90 days of the birth of such child.

SECTION 3. CANCELLATION

A. Cancellation by Insureds

You may cancel coverage under this contract (including for individual Insureds) at any time by contacting the Exchange, if this plan was purchased through the Exchange. Cancellation will be effective no later than 14 days, for an Exchange plan, after the Insured's request for coverage to be discontinued. In the event of cancellation or death, the earned premium will be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the Insured resided when the policy was issued and the unearned portion of any premium will be promptly returned. Cancellation will occur without prejudice to any claim originating prior to the effective date of cancellation.

B. Cancellation by the Exchange and/or Company

1. Coverage under the contract may be cancelled only in the following circumstances:
    a. The Insured is no longer eligible for coverage in a QHP through the Exchange. The last day of coverage is the last day of the month following the month in which notice is sent by the Exchange unless an earlier cancellation date is requested and approved by the Exchange.
    b. Nonpayment of premiums when:
        (1) The 3-month grace period required for individuals receiving advance premium tax credits has been exhausted. Under these circumstances, the last day of coverage will be the last day of the first month of the 3-month grace period; or
        (2) A grace period of 10 days following the premium due date has been exhausted for Insureds not receiving advance premium tax credits. Unless premiums are received by the end of the stated grace period, coverage under this contract cancels as of the payment due date.
    c. The Insured's coverage is rescinded in the event of fraud or intentional misrepresentation of a material fact.
    d. The QHP cancels or is decertified.
    e. The Insured changes from coverage under this contract to another QHP during an annual open enrollment period or special enrollment period.
    f. The Insured is newly eligible for Medicaid, CHIP or Basic Health Program (BHP) coverage. Cancellation of coverage will be effective the day before such coverage begins.
    g. Dependents who no longer qualify under the general definition of Insured.

SECTION 4. MEDICAL BENEFITS AND EXCLUSIONS

Coverage Provided

A. The coverages becoming effective on the Effective Date of this Policy are only those shown in the Schedules of Benefits. Any coverage which is not shown in the applicable Schedule is not provided.

B. To receive benefits from your coverage, you must use a Network Provider. However, payment will be made at the Network Provider level of benefits for services provided by an Out-of-Network Provider when the services are provided for a Medical Emergency. The Company will provide the Insured with listings of the Network Providers in the Company Service Area. The Company has no obligation to advise the Insured of the applicability of additional payment provisions for use of an Out-of-Network Provider during the course of pre-authorization or otherwise. The Insured is responsible for choosing their providers of health care services.

Schedule of Benefits

Description of Covered Medical Expenses: The Company will pay a percentage of Covered Medical Expenses incurred by an Insured to the extent those charges exceed any Deductible and/or Copay and/or Coinsurance amounts provided in the Schedule of Benefits.

Deductible

A Deductible amount, as outlined in the Schedule of Benefits, shall be applied to certain Covered Medical Expenses incurred by an individual eligible for benefits in any Plan Year. Expenses incurred by an individual eligible for benefits in any Plan Year will be the amount that must be satisfied before the individual is entitled to benefits.

Family Deductible - After the Family Deductible is satisfied, no further Deductible amount will be required for medical benefits to be payable for all family members in the Plan Year, if family (more than one individual) coverage is provided.

Cost Sharing Maximum

After the Cost Sharing Maximum has been reached, the Company will pay 100% of the Covered Expenses indicated in the Schedule of Benefits, excluding amounts that exceed Reasonable and Customary and other limitations.

Covered Medical Expenses include:

A. Semi-Private Room and Board and Intensive Care Unit accommodations furnished to an Insured by a qualified Acute Care Hospital while the Insured is an Inpatient.

B. Acute Care Hospital services and supplies furnished by a qualified Acute Care Hospital to an Insured, for their use while an Inpatient or Outpatient, such as operating room, x-rays, laboratory tests, drugs, medicines, general nursing care, anesthesia, radiation therapy, and blood or blood plasma.

C. Hospice Care Program expenses if a Physician's statement is received which verifies that the Insured's life expectancy is no longer than 6 months. The exclusion for Custodial Care does not apply to Hospice Care Program benefits.

Hospice Care Program expenses include:

1. Inpatient hospice care at the facility's average Semi-Private Room and Board rate.
2. Physicians' services.
3. Home health care services, including:
   a. Part-time nursing care rendered in the Insured's home by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Public Health Nurse.
   b. Physical therapy provided in the Insured's home.
   c. Use of medical equipment.
4. Respite care.
5. Prescription drugs.
6. Bereavement services for other members of the Insured's family provided that they are also Insureds under the Policy. These services are eligible for a period not to exceed 6 months and only if the Hospice Care Program benefit was used by the terminally ill Insured.

D. Medical supplies and treatment, home and office visits by a Physician and other medical care as deemed necessary for the treatment of an Illness or Injury which includes visits offered via Telemedicine.

E. Benefits for visits by an In-Network Provider to an Inpatient during the period of Confinement.

F. Benefits for visits by an Out-of-Network Provider during a period of Confinement where surgical or obstetrical services are furnished only if the Physician provides evidence, satisfactory to the Company, that the visits are necessary and different in kind and nature from those customarily rendered and considered to be surgical or obstetrical services.

G. Services of a consulting Physician with special skill or knowledge to assist in diagnosis or treatment for one consultation during each continuous period the patient is Confined. No benefits are payable for staff consultations required by the facility’s rules or regulations.

H. Surgical Procedures including preoperative and postoperative care.

I. Services of a technical surgical assistant when deemed to be required for a Surgical Procedure not routinely available as a service provided by an Acute Care Hospital intern, resident, or full-time, salaried Physician.

J. Generally accepted operative and cutting procedures necessary for the diagnosis and treatment of Illnesses, Injuries, fractures and dislocations, including any necessary preoperative and postoperative care and, where included as part of such service, anesthesia administered by the Physician or Certified Registered Nurse Anesthetist.

K. Private duty nursing services by a Registered Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.). Nursing services must be prescribed by a qualified Physician.

L. Licensed ground or air ambulance services for emergency or Medically Necessary transportation to the nearest facility equipped to handle the condition and within a 500 mile radius.

M. Emergency Care including Emergency Room Services. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which we determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service.

- The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be:
  - The amount negotiated with Network Providers for the Emergency service furnished;
  - The amount for the Emergency Service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
  - The amount that would be paid under Medicare for the Emergency Service.
- In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

N. For services received for urgent care, including facility charges at an Urgent Care Center.

O. Anesthetics, oxygen and their administration by a Physician or Certified Registered Nurse Anesthetist.

P. Blood and blood plasma, and their administration including necessary expenses related to self-donated blood.

Q. Artificial limbs (except myoelectric limbs), artificial eyes, and artificial larynx for an Illness or Injury, Covered Expenses do not include charges for replacement or repair or maintenance, unless made necessary by bodily growth or development or irreparable damage due to normal wear.

R. Electronic heart pacemaker for an Illness or Injury, not including charges for replacement or repair or maintenance. Covered Expenses do not include charges for replacement or repair or maintenance, unless made necessary by bodily growth or development or irreparable damage due to normal wear.

S. Surgical dressings, casts, splints, trusses; orthotics, braces (including attached corrective shoes) for an Illness or Injury and shoes prescribed for a person with diabetes. Covered Expenses do not include charges for replacement or repair or maintenance, unless made necessary by bodily growth or development or irreparable damage due to normal wear.

T. Crutches, prostheses, and similar medical supplies for an Illness or Injury. Covered Expenses do not include charges for replacement or repair or maintenance, unless made necessary by bodily growth or development or irreparable damage due to normal wear.

U. Rental (or at the Company's option, purchase, if the Company determines that the cost of purchase is less than anticipated total rental charges) of a wheelchair, oxygen tent, hospital bed,

nebulizer, ventilation equipment or other similar durable medical equipment. The durable medical equipment must be primarily medical in nature, not normally of use in the absence of Illness and Injury. Covered Expenses do not include charges for replacement or repair or maintenance, unless made necessary by bodily growth or development or irreparable damage due to normal wear. Coverage is limited to the most cost effective durable medical equipment that meets the Covered person's medical needs.

V. Diagnostic x-rays, electrocardiograms, electroencephalograms, laboratory testing and pathological examinations when performed by a Physician for the diagnosis of an Illness or Injury.

W. Physical therapy treatment by a licensed physiotherapist and occupational therapy by a licensed occupational therapist. These services must be due to an Injury or Illness and to improve bodily function.

X. X-ray and radium treatments and treatments with other radioactive substances.

Y. Treatment by a licensed, qualified speech therapist for the purpose of restoring speech loss or correcting an impairment due to:
1. a congenital defect; or
2. an Injury or Illness, except a mental, psychoneurotic or personality disorder.

Z. Dental services needed to correct damage to Sound Natural Teeth caused by accidental Injury when treatment begins within 30 days of the accident.

AA. Acute Care Hospital expenses associated with dental procedures while an Inpatient when a concurrent hazardous medical condition exists.

BB. Acute Care Hospital services in connection with admissions for multiple extractions or removal of unerupted teeth while the Insured is Hospitalized as an Inpatient.

CC. Care for routine nursery charges for a newborn child. The requirement that the Confinement be as a result of Injury or Illness will not apply with respect to the charges incurred in connection with the Confinement of a newborn child while such child's mother is Confined in the Acute Care Hospital. Also eligible shall be the routine Physician visits during the initial Confinement.

DD. Pre- and postnatal care, including examination and testing of the newborn and required visits to the doctor's office and Medically Necessary laboratory tests related to a covered Pregnancy.

EE. Routine and necessary immunizations for each newly born child from birth to 72 months which includes but is not limited to: at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B; two doses of vaccine against measles, mumps and rubella; one dose against varicella and other vaccines and dosages as may be prescribed by the Indiana Department of Health and Welfare. This includes newborn screening test for Adrenoleukodystrophy(ALD).

FF. Charges for or in connection with circumcisions for newborn males.

GG. One contact lens per eye following cataract surgery.

HH. Chemotherapy and drugs used in antineoplastic therapy are payable on the same basis as for any other prescribed drugs covered under the Policy. The drug must meet the following conditions:

1. It is ordered by a Physician for the treatment of a specific type of neoplasm.

2. It is approved by the Federal Food and Drug Administration for use in antineoplastic therapy.
3. It is used as part of an antineoplastic drug regimen.
4. Its efficacy is substantiated by current medical literature and recognized oncology organizations generally accept the treatment.
5. The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

II. All Skilled Home Health Care services including home infusion and related services, require Prior Authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records to review to determine whether services are eligible under this contract. Visits are limited to 100 days per calendar year.

a. Covered services that require that the patient be homebound:
An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

(1) Skilled Nursing Care visits include services provided by a Home Health Agency on an intermittent per visit basis.

(2) Physical, Occupational, and Speech therapy provided by a Home Health Agency, on a per visit basis.

(3) Social Worker services are covered when provided by a Home Health Agency, on a per visit basis.

b. Covered services that do not require that the patient be homebound:

(1) Home care education associated with diabetes, colostomy care, wound care, IV therapy or any other condition or treatment which the Company has determined is appropriate for home care education, when provided by a Home Health Agency. Benefits for educational services will be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.

(2) Home infusion and related services. These services can be provided by either a Home Health Agency.

c. Skilled Nursing Care services do not include:

(1) Services provided by a member of the Insured's immediate family.

(2) Services provided by a person who normally lives in the Insured’s home.

(3) Custodial/Maintenance Care. The Company has the right to determine which services are Custodial/Maintenance Care.

JJ. Skilled Nursing Facility expenses if:

1. The Insured was first an Inpatient in an Acute Care Hospital for at least 3 consecutive days;
2. A Physician orders Skilled Nursing Facility confinement for convalescence from a condition which caused that Acute Care Hospital stay or related conditions;
3. The Skilled Nursing Facility confinement begins within 14 days after discharge from that Acute Care Hospital stay, or within 14 days after a related Skilled Nursing Facility stay; and

4. The Insured is under a Physician's continuous supervision and requires 24-hour nursing care and there is a personal examination at least once every 7 days.

Covered Skilled Nursing Facility expenses include:

1. Skilled nursing visits are limited to 90 visits per calendar year;
2. Semi-Private Room and Board;
3. Other services and supplies ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care; or
4. Services provided in the course of treatment of the Insured by an anesthesiologist, pathologist, physical therapist, occupational therapist, speech therapist, or radiologist.

No Skilled Nursing Facility benefit shall be a payable charge for:

1. confinement that does not meet the above requirements for Skilled Nursing Facility benefits;
2. personal items and private duty nursing or other professional services, unless the patient is under the continuous care of their physician or unless 24-hour nursing care is essential; or
3. Custodial Care.

Psychiatric Treatment including:

1. Acute Care Hospital and Psychiatric Facility admissions;
2. Outpatient psychiatric services when furnished and billed for by a Psychiatric Facility or Partial Hospital Program;
3. Day care and night care provided by Acute Care Hospitals or Psychiatric Facilities. All eligible charges in connection with this care shall be considered as Inpatient charges:
   a. Professional and other staff and auxiliary services made available to ambulatory patients;
   b. Prescribed drugs and medications dispensed by the Acute Care Hospital for psychiatric day care and night care or by the Psychiatric Facility, when dispensed in connection with Treatment received at the Acute Care Hospital or Psychiatric Facility;
4. Electroshock therapy when administered by a Physician;
5. Anesthesia for electroshock therapy when administered by a Physician other than the Physician administering the electroshock therapy;
6. Psychological testing rendered by a Physician;
7. Individual or family counseling rendered by a Physician;
8. Private duty nursing in the Acute Care Hospital, Psychiatric Facility, Partial Hospital Program, or at home limited to 82 visits per calendar; and
9. Treatment must be rendered in an approved facility by an M.D., Ph.D., or licensed Social Worker.

KK. Treatment for Mental/Behavioral Health and Substance Use Disorder. See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Service, Outpatient Services, and Physician visits for the treatment of Mental/Behavioral Health conditions is provided in compliance with state and federal law.

LL. Ambulatory Care Center or Acute Care Hospital Outpatient facility charges in connection with a covered Surgical Procedure.

MM. Pre-admission Testing within 10 days before surgery.

NN. Outpatient Surgery Expense including services and supplies connected to the procedure furnished within 24 hours after the surgery:

1. Physician's services
2. Necessary supplies

OO. Human Organ & Bone Marrow Transplant Benefits are provided for the following human organ transplants:

a. Cornea

b. Heart

c. Heart-lung

d. Kidney

e. Kidney-liver

f. Liver

g. Lung (whole or lobar, single or double)

h. Multivisceral transplants

i. Pancreas

j. Pancreas-kidney

k. Small intestine

There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

Benefits for a human organ transplant will be available for a live donor (whether or not an Insured), if the recipient is an Insured, unless the donor has other coverage.

l. Bone Marrow and or/ peripheral stem cell transplant. (High-Dose Chemotherapy with Hematopoietic Support)

Benefits are available only when pre-certified and the treatment particular for the Insured's condition is not Experimental or Investigational.

Benefits will be available for the costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available.

PP. Preventive Care and Screening Services and Immunizations for children, adolescents and adults (provided by an In-Network provider only).

Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:

-- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or

-- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or

-- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved.

Please consult the recommendations and guidelines for age, frequency and other guidelines. Some examples of screening include high blood pressure, breast cancer (mammograms), cervical cancer (PAP), cholesterol, depression, diabetes, colorectal cancer (colonoscopies), and prostate cancer (PSA). Examples of immunizations include HIV, DTP, Hepatitis A, Hepatitis B, HIB, HPV, MMR, and Flu Shots.

Prostate screening covers all men 50 years or older and only for those men 40 years of age or older which are symptomatic or in a high-risk category. The screening includes a prostate-specific antigen blood test and a digital rectal examination.

Coverage for services related to diagnosis, treatment and management of osteoporosis for individuals with a condition or medial history for which bone mass measurement is Medically Necessary.

Colorectal cancer examinations and laboratory tests for cancer for any non-symptomatic Insured, in accordance with the American Cancer Society guidelines, for an Insured:

A. Who is at least 45 years old; or
B. Less than 45 years old and at high risk for colorectal cancer in accordance with the American Cancer Society guidelines.

Copies of the recommendations and guidelines may be obtained from the following web sites. You may also call [800-211-1534] to obtain a no-cost paper copy from US Health and Life.

https://www.healthcare.gov/what-are-my-preventive-care-benefits/
www.cdc.gov/vaccines/Pubs/acip-list.htm
Official web site of the U.S. Health Resources & Services Administration | (hrsa.gov)

QQ. Hemodialysis.

RR. Second surgical opinions.

SS. Birthing Center.

TT. Phase I and Phase II Cardiac Rehabilitation services shall be covered within 3 months of the following: post-myocardial infarction; post-coronary bypass; post-percutaneous transluminal angioplasty; post-cardiac transplantation; post-pathway ablation; post-AICD implantation; angina pectoris (Class III or IV); myocardial disease (Class III or IV); and dangerous arrhythmias. No benefits are provided for maintenance or unsupervised programs, or the purchase or rental of exercise equipment in connection with Cardiac rehabilitation.

UU. Charges for or in connection with a mastectomy including the following:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgical Procedures and reconstruction of the other breast, to produce a symmetrical appearance;
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
4. Benefits are not provided for items of wearing apparel except coverage is available for two (2) post-mastectomy bras per insured per benefit period. A post mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prosthesis.

VV. Breast cancer diagnostic screening services, as an Inpatient or Outpatient:

1. 2-view, low dose radiation mammography;
2. surgical breast biopsy and pathologic examination and interpretation;
3. one service during the 5-year period for an Insured aged 35-40, unless deemed necessary by a Physician regardless of when the last service was completed and age of the Insured;
4. one service each Plan Year for an Insured aged 40 or older, unless deemed necessary by a Physician regardless of when the last service was completed and age of the Insured.

WW. For mothers and newborns, an Acute Care Hospital admission of 48 hours following a normal delivery, or 96 hours following a Cesarean delivery, will be allowed for an eligible admission. This includes the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child.

XX. Prescribed syringes, needles, and colostomy bags.

YY. Surgical and Non-Surgical services of a reversible nature to treat temporomandibular, craniomandibular, head and neck neuromuscular or similar disorders requires prior authorization and is, subject to the following:

1. a single examination including allowances for all models, electronic diagnostic testing, psychological testing and photographs;
2. physical therapy of necessary frequency and duration and limited to a multiple modality benefit recommendation when more than one therapeutic treatment is rendered on the same date of treatment;
3. therapeutic injections;
4. appliance therapy based on the usual and customary fee for use of a single appliance, regardless of the number of appliances used, including an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance
5. there can be no pre-estimates of the frequency or duration of TMJ-related treatment and services.

ZZ. Diabetes program to prevent the onset of clinical diabetes emphasizing best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

1. Coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

    a) Blood glucose monitors and blood glucose monitors for the legally blind.
    b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
    c) Syringes.
    d) Insulin pumps and medical supplies required for the use of an insulin pump.
    e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition, subject to the following:
        i. Is limited to completion of a certified diabetes education program upon occurrence of either of the following:
            1. If considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
            2. If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.

ii. Shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

2. As used in this Covered Expense, “diabetes” includes all of the following:

a. Gestational diabetes.
b. Insulin-dependent diabetes.
c. Non-insulin-dependent diabetes.

AAA. Allergy testing, evaluations and injections, including serum costs.

BBB. Routine Podiatric Care only when a disease such as diabetes exists which can potentially affect circulation and/or the loss of feeling in the lower limbs.

CCC. Consultations with a dietician employed by an In-Network Provider. Some dietician services may be covered under the Preventive Care benefit.

DDD. Education conducted by In-Network Providers about managing chronic disease states such as diabetes or asthma.

EEE. Maternity classes conducted by In-Network Providers.

FFF. Evaluation and treatment of chronic and/or acute pain as specified in our medical policies.

GGG. Reconstructive surgery to correct congenital defects and/or effects of Illness or Injury, if:

1. The defects and/or effects of Illness or Injury cause clinical functional impairment. “Clinical functional impairment” exists when the defects and/or effects of Illness or Injury:

   a. Cause significant disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested);
   b. Interfere with employment or regular attendance at school;
   c. Require surgery that is a component of a program of reconstructive surgery for a congenital deformity or trauma; or
   d. Contribute to a major health problem; and

2. We reasonably expect the surgery to correct the condition; and

3. The services are approved in advance by us and you receive them within two years of the event that caused the impairment, unless either of the following applies:

   a. The impairment caused by Illness or Injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem was identified; or
   b. your treatment needs to be delayed because of developmental reasons.

   We will cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain an Insured.

HHH. Pulmonary rehabilitation.

III. Biofeedback for treatment of medical diagnoses.

JJJ. Chiropractic treatment.

KKK. Tobacco smoking cessation services provided by an In-Network Physician. Some screening, counseling, and interventions may be covered under the Preventive Care benefit.

LLL. Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy, are Covered.

MMM. Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies, and equipment needed to administer this type of nutrition is covered.

NNN. Services provided by an Inpatient Rehabilitation Facility.

OOO. Services provided by a Long Term Acute Care Facility.

PPP. Facility, ancillary, and anesthesia services for limited dental services may be covered when:

1. A child or insured has a concurrent serious medical condition that may interfere with routine dental work or;
   A child:
   - Under the age of five years of age and needs multiple extractions or restorations
   - A total of six or more teeth are extracted in various quadrants

   An insured with a concurrent serious medical condition that may interfere with routine dental work such as:
   - Dental needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
   - Extensive oral-facial and/or dental trauma has occurred causing treatment under local anesthesia to be ineffective or compromised due accidental dental injury
   - Medical services, such as suturing of lacerations required in connection with covered oral surgery due to accidental injury oral surgical services to sound natural teeth
2. Administration of general anesthesia and medical care facility charges for dental care are covered for:
   - A child five years of age and under; or
   - A person who is severely disabled; or
   - A person has a medical or behavioral condition, which requires hospitalization or general anesthesia when dental care is provided.

QQQ. Covered oral surgical (Medical) services within an office setting may include:
- Surgical procedures of the jaw and gums
- Removal of tumors and cysts of the jaws, cheeks, lips, tongue roof and floor of the mouth
- Surgical removal of impacted teeth, benign or malignant lesions (not including inflammatory lesions)

- Medical services, such as suturing of lacerations required in connection with covered oral surgery due to oral surgical services to sound natural teeth.

RRR. One hearing screening, performed as part of a physical exam, during each calendar year to determine hearing loss as determined within routine preventive screening – USPSTF preventive services.

SSS. One vision screening, performed as part of a physical exam, during each calendar year to determine vision loss as determined within routine preventive screening according to USPSTF preventive services.

TTT. Routine Patient Care Costs associated with the provision of covered services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered under this policy if those drugs, items, devices, treatments, diagnostics, and services were not provided in connection with an Approved Clinical Trial program including covered services typically provided to patients not participating in a Clinical Trial.

Qualified Individuals will not be denied participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening disease or condition. A Qualified Individual will not be discriminated against on the basis of participation in such trial.

The Qualified Individual may participate in an Approved Clinical Trial through an In- Network provider if the provider will accept the Qualified Individual as a participant in the trial. However, this does not prevent a Qualified Individual from participating in an Approved Clinical Trial conducted outside of the state in which the individual resides.

UUU. Women's Preventive Services, including:

1. Contraceptives for all FDA-approved methods for women as required by PPACA, to include prescriptions, surgery and over-the-counter items as well as related counseling, office visits, inpatient and outpatient facilities and physician's services. This includes coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office);
2. Sterilization of females, including tubal ligation and associated charges (anesthesia, labs, etc.);
3. Manual and electrical breast pumps per pregnancy when purchased or rented from a licensed provider or purchased from a retail outlet. Hospital-grade pumps are not covered;
4. Lactation support and counseling from a licensed provider (in hospital or in office);
5. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and first prenatal visit for pregnant women at high risk for diabetes;
6. Human papillomavirus (HPV) screening;
7. Annual counseling for sexually transmitted infections during well-woman visits for all sexually active women;
8. Screening for interpersonal and domestic violence.

VVV. Pediatric vision benefits for children under age 19:

1. Routine eye exams as needed when provided by ophthalmologists and optometrists;
2. One pair of standard eyeglasses or contact lenses every calendar year (contact lenses are in lieu of eyeglasses);
3. One frame every calendar year.

WWW. Blepharoplasty of upper lid.

XXX. Breast reduction.

YYY. Surgical treatment of male gynecomastia.

ZZZZ. Sleep Apnea treatments including oral pharynx procedures. Refer to Utilization Management for Prior Authorization requirements.

AAAA. Benefits are provided for a penile prosthesis required for physiological (not psychological) impotence, subject to advance approval by the Company only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when individual situation warrants coverage in the Company's opinion. Subject to prior authorization.

Benefits are not provided for services of sleep laboratories for nocturnal penile tumescence testing.

BBBB. Benefits for medical food that is Medically Necessary; and prescribed by the Insured's treating physician for treatment of the covered Insured's inherited metabolic disease.

CCCC. Charges for services rendered in connection with the diagnosis and treatment of Autism Spectrum Disorders. Coverage is limited to treatment that is prescribed by the Insured's treating Physician in accordance with a treatment plan.

DDDD. Benefits for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset pediatric acute-onset neuropsychiatric syndrome (PANS) including treatment with intravenous immunoglobulin therapy.

Outpatient Prescription Drug Benefits

Prescription Drugs obtained from a Participating Pharmacy. You may call the 800 number on your identification card for assistance in a Participating Pharmacy.

The Formulary is subject to change. Drugs may be deleted from the Formulary during the year if significant safety issues arise, or if new products come to the market that are superior in efficiency and or safety. If a new drug is determined as safe and effective as currently available therapies, the cost effectiveness of the drug is reviewed. Typically, if the cost is comparable or better than existing therapies, the drug is added to the Formulary. Drugs listed on the Formulary will be included in Covered Drugs if they not excluded, the appropriate Copay and/or Deductible and Coinsurance is paid, and any required Prior Authorization is received.

Some Prescription Drugs are subject to Step Therapy. Step Therapy is an automated process that defines how and when a particular drug can be dispensed based on your drug history. Step therapy usually requires the use of one or more prerequisite drugs prior to the use of another drug.

You may request access to clinically appropriate drugs not covered or obtain a copy of the current Formulary at no charge by contacting us at:

Address:	US Health and Life Insurance Company Attention: Customer Service [8220 Irving Road Sterling Heights, MI 48312]
Telephone:	[800-211-1534]
Fax:	[586-693-4321]
Website:	[www.ascensionpersonalizedcare.com]

Covered Prescription Drugs
The Company covers only drugs that are:

A. Orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

B. Approved for treatment of the Insured's Sickness or Injury by the Food and Drug Administration (FDA); or

C. Approved by the Food and Drug Administration (FDA) for the treatment of a particular diagnosis or condition other than the Insured's and recognized as appropriate medical treatment for the Insured's diagnosis or condition in one or more of the Standard Reference Compendia or recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal; and

D. Satisfy the following:

(1) Federal legend drugs that bear the legend Caution: Federal law prohibits dispensing without a prescription;
(2) Compounded medications in which at least one ingredient is a legend drug;
(3) Drugs prescribed for non-FDA approved use (Off-Label use) may be covered if all of the following conditions are met:
(a) the drug is approved by the FDA;
(b) the drug is prescribed for the treatment of a life-threatening condition or a chronic and seriously debilitating condition;
(c) the drug has been proven effective and accepted for the treatment of the specific indication for which it has been prescribed in any one of the Standard Reference Compendia or in Medical Literature; and
(d) Prior Authorization has been received from the Company.
(4) Insulin syringes (no Copay when dispensed with Insulin);
(5) Diabetic devices, needles, supplies, testing reagents;
(6) Blood glucose strips, limited to 100 strips per a 25-day period; additional strips may be available subject to Prior Authorization;
(7) Glucose (blood sugar) monitors limited to one per two-year period;
(8) Lancets or Microlet Vaculance;
(9) Prenatal Vitamins for females between the ages of 10 and 65 years old;
(10) Over-the-counter preventive care medication if prescribed by a Physician.

If you want to obtain a complete list of Covered Drugs, please contact the Company for its current list.

Only drugs that are obtained by a Prescription Order, are not excluded, and are Medically Necessary are covered. Benefits subject to Prior Authorization are covered only to the extent that the Insureds satisfies the Prior Authorization requirements.

Where there is a Generic Drug equivalent available for a Brand Name Drug the Insured is responsible for the Brand Name Drug Copay and the difference in price between the Brand Name Drug and the Generic Drug, unless the prescribing Physician provides a letter of Medical Necessity supporting the use of the Brand Name Drug for a specific medical reason.

Dispensing Limits: The quantity of Prescription Drugs dispensed pursuant to a Prescription Order or refill will be that quantity usually prescribed by the Physician, not to exceed the quantity required for 34 consecutive days supply with the following exceptions:

A. one (1) vial of insulin;

B. eight (8) fluid ounces of liquid medication;
C. three (3) ounces net weight of ointment or cream;
D. a 14-day supply of antibiotics;
E. 90 days supply for Home Delivery (if the Home Delivery Option is selected);
F. a sufficient supply to provide appropriate continuing medication during an Insured's quote temporary absence from an area where a Participating Pharmacy is available, subject to prior review and approval by US Health and Life Insurance Company.

New prescriptions for, or refills of, a previously obtained Prescription Drug are not covered until 75% of the medication obtained has been used (unless Prior Authorization is obtained).

Drugs Covered Subject to Prior Authorization
Prior Authorization means that a request has been submitted to the Company or to the Pharmacy Benefit Manager (PBM) identified on the identification card for a determination as to whether the requested Prescription Drug is Medically Necessary and is medically appropriate treatment for the condition for which it is prescribed.

Prior Authorization is intended to encourage appropriate and cost-effective medication use. The Pharmacy Benefit Manager has relied on a clinical team of physicians and pharmacists to identify, develop and approve clinical criteria for medications that are appropriate for Prior Authorization by reviewing FDA-approved labeling, scientific literature and nationally recognized guidelines.

Drugs and drug classes subject to Prior Authorization are chosen based on a variety of factors, including current medical findings, FDA information, and the availability of other cost-effective treatments available in the marketplace.

If the Insured is prescribed a drug that is subject to Prior Authorization, the drug will not be dispensed without Prior Authorization obtained by Insured's physician. If Prior Authorization is obtained, the drug will be dispensed and is subject to the Prior Authorization penalty. If Prior Authorization is denied, the drug will not be dispensed, and the Insured will be notified of the proper appeals procedure. The drugs subject to Prior Authorization are subject to change.

You may obtain a copy of the current list of Prescription Drugs that require Prior Authorization at no charge by contacting us at:

Address: US Health and Life Insurance Company
Attention: Customer Service
[8220 Irving Road
Sterling Heights, MI 48312]
Telephone: [800-211-1534]
Fax: [586-693-4321]
Website: [www.ascensionpersonalizedcare.com]

Prescription Drug Exception Process
Providers or Covered Individuals may request and gain access to a drug not on the plan's formulary under certain situations. The Covered Individual's provider may recommend a particular service or FDA-approved item based on a determination of Medical Necessity with respect to that individual. Under this process, we will notify the Covered Individual, the Insured's designee and physician of Our decision within 72 hours after we receive the exception request. The Covered Individual or the Covered Individual's designee/physician may request an expedited exception based on exigent circumstances and receive notification no later than 24 hours after making the request.

Prescription Drug Exclusions
Prescription Drug Benefits are subject to the General Exclusions. In addition, Prescription Drug Benefits will not be paid for the following charges:

1. for the administration of any drug, however done, including but not limited to injection, implantation, insertion, topical application; or

2. for medical supplies, therapeutic devices or appliances, including needles or syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically described in Covered Prescription Drugs section; or

3. for a Prescription Drug for treatment of military service-related disabilities, Sicknesses or Injuries when the Insured is legally entitled to other coverage for Prescription Drugs furnished by or made available by an agency of the U.S. Government or a foreign government and for which facilities are reasonably available to the Insured regardless of whether the Insured has requested such coverage; or

4. for a Prescription Drug for treatment of Sicknesses or Injuries due to participation in a riot or insurrection; or

5. for experimental drugs not otherwise approved for any indication by the FDA, except in cases for treatment of cancer where the drug is recognized for treatment in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

6. for non-FDA approved drugs, dosage forms, strengths or indications or uses, except as may be described in the COVERED PRESCRIPTION DRUGS section; or

7. for DESI Drugs, drugs designated by the Food and Drug Administration as less than effective, except the DESI Drugs indicated on the attached Covered DESI Drug list; or

8. for any drug where the FDA has determined its use to be contraindicated, that is a use for which a medication or treatment should not be administered, such as giving a drug to a person who is allergic to that drug; or

9. for over-the-counter drugs and drugs with over-the-counter equivalents. This exclusion does not apply to insulin and supplies related to insulin or preventive care medications if prescribed by a Physician;

10. for a Prescription Drug which is to be taken by or administered to an Insured, in whole or in part while he is an inpatient in an institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; or

11. for any Prescription Drug refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original Prescription Order; or

12. for all irrigating solutions and intravenous infusion; or

13. for drugs used for cosmetic purposes except as described in the COVERED PRESCRIPTION DRUGS section

14. for syringes, except described in the COVERED PRESCRIPTION DRUGS section; or

15. for obsolete drugs (drugs more than 2 years past the listed expiration date); or

16. for New Drugs, when the drug is in a class of drugs listed below; or

17. for any of the following drugs:

    a. abortificants, except this exclusion does not apply to emergency pregnancy prevention medication obtained from a Participating Pharmacy;

c. adrenergic agents, except as may be shown under “Covered Prescription Drugs”;
d. oxycontin and duragesic;
e. antiobesity and weight loss drugs;
f. biologicals, such as allergens, serums, toxoids, and vaccines;
g. blood, blood products, and blood plasmas;
h. contraceptive devices;
i. dietary supplements;
j. fluoride preps;
k. gold compounds;
l. hair growth reduction agents;
m. injectable medications, except as may be shown under “Covered Prescription Drugs”;
n. miscellaneous medical supplies, including but not limited to, urine tests, glucometers (non Ascensia brands), non-insulin syringes, non-insulin and over-the-counter- products, unless required by law;
o. nutritional supplements;
p. obsolete drugs;
q. research drugs, unless required by law; and
r. topical minoxidil (e.g. Rogaine).

SECTION 5. UTILIZATON MANAGEMENT REQUIREMENTS

Utilization Management
Benefits due to Insureds are subject to the following Utilization Management provisions:

Prior Authorization Review is intended to confirm the Medical Necessity and Medical Appropriateness of a setting, service, treatment, supply, device, or prescription drug. If a setting, service, treatment, supply, device, or prescription drug is listed below, Prior Authorization Review must be obtained before incurring any claims for that setting, service, treatment, supply, device, or prescription drug. You are responsible for obtaining Prior Authorization Review when required. You can obtain Prior Authorization Review by contacting us at:

Address:	US Health and Life Insurance Company [8220 Irving Road Sterling Heights, MI 48312]
Telephone:	[800-856-3775]
Fax:	[586-693-4829]
Website:	[www.ascensionpersonalizedcare.com]

Prior Authorization is not a guarantee that benefits will be payable. All benefits payable are subject to all of the terms, conditions, provisions, exclusions, and limitations of the Policy.

The following settings, services, treatments, supplies, devices, or prescription drugs require Prior Authorization Review:

- Inpatient admissions (including acute care, long term acute care- behavioral health and/or substance abuse use disorder rehabilitation, residential treatment and partial hospitalization; skilled nursing facility).
- Emergency admissions within 48 hours following admission
- High Risk Maternity (routine that exceeds federal requirements)
- Outpatient Surgical Procedures
- Oral Pharynx Procedures
- Spinal Procedures
- Diagnostic Radiology
- Therapeutic Radiology
- Neuropsychological Testing
- Orthotics and Prosthetics
- Durable Medical Equipment (including DME items more than $1000)
- Hearing (EAR) devices
- Transplants (other than Corneal Transplants)
- Home Health Care
- Home Infusion Therapy
- Rehabilitative and Habilitative Outpatient Therapy
- Injectable Medications (administered by a healthcare provider)
- Genetic Testing

**Potential Experimental or investigation treatment, testing or procedures*List of services requiring prior authorization is not all inclusive.*

Failure to utilize or abide by the decisions of the Utilization Management Program will result in the denial of the claim for failing to prior authorize in advance of the proposed procedure or admission.

SECTION 6. GENERAL EXCLUSIONS

The calculation of benefits payable under this Policy shall not include or be based upon any charge:

1. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished before the effective date of coverage of the Insured on whose account the charge is made or which was furnished in connection with or during a Confinement which commenced before that date; or

2. for which a claim for benefits is made more than one year after the expense is incurred; or

3. for services incurred after eligibility is terminated; or

4. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished without the recommendation and approval of a Physician or Dentist acting within the scope of his license; or

5. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service, supply, or drug that is not Medically Necessary to the care and treatment of any Injury or Illness of the Insured on whose account the charge is made, unless such procedure is specifically listed as eligible under Covered Medical Expenses; or

6. for services rendered for treatment of an Injury or Illness for which benefits are available under Workers' Compensation or Employer liability law, or services rendered for any Injury or Illness sustained as a result of any work for wage or profit; or

7. for services rendered in connection with an Injury or Illness that is not a Non-occupational Injury or Illness; or

8. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished by or through any government or any subdivision or agency of a government, or the charge for which is paid or payable or reimbursable by or through any policy or program of any government or any subdivision or agency of a government, other than a policy, plan or program of a government or of a subdivision or agency of a government unless payment is legally required; or

9. which would not have been made in the absence of coverage or professional courtesy service, or which the Insured is not legally obligated to pay or to the extent that the Company is prohibited from providing benefits for such charge, by any law or regulation; or

10. for Out-of-Network charges in excess of the Reasonable and Customary Charges; or

11. for which any loss to which a contributing cause was the Insured’s commission of or attempt to commit a felony or to which a contributing cause was the Insured’s being engaged in an Illegal Occupation.

12. for any loss sustained or contracted in consequence of the Covered Person’s being Intoxicated or under the influence of any narcotic or alcohol, unless administered on the advice of a Physician, or illegal drug. Expenses will be covered for injured covered persons other than the person misusing alcohol or illegal drugs.

13. for treatment for learning disabilities, behavioral modification or developmental disorders with the exception of diagnosis and treatment of Autism Spectrum Disorders; testing or training for education or vocation; speech therapy for other than acute traumatic injury or functional defect; vision therapy including eye exercises;

14. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply for which benefits are furnished, paid for, or required by reason of service in the armed services of any country; or

15. for treatment or services that were received outside of the United States, its protectorates, Canada or Mexico, except if the treatment is for a Medical Emergency; or

16. for care, treatment, services, and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care; or

17. for procedures, treatment, services, supplies or drugs which are considered as Experimental Treatment or investigative; or

18. for procedures, treatment, services, supplies or drugs not approved by the Federal Food and Drug Administration of the United States; or

19. for Custodial Care or charges made by a Custodial Care Facility; or

20. for an Inpatient admission primarily for physical check-ups, observation, and rest cures; or

21. for the difference between a Semi-Private Room and Board rate and a private room and board rate; or

22. for Confinement for procedures and services not covered under the Policy; or

23. for charges incurred as a result of an Inpatient admission of a non-emergency, non-life-threatening situation occurring on a Saturday or Sunday; or

24. for professional services of a person who ordinarily resides in the Insured's home or is a member of the Insured's family. For the purpose of this item family consists of the Policyholder, spouse, children, brothers and sisters, and parents of the Policyholder; or

25. for anesthesia for procedures that are not covered by the Policy; or

26. for charges for medical treatment or visits which consist only of a telephone communication; or

27. for air conditioners, purifiers, humidifiers, heating pads, hot water bottles, and other related equipment; or

28. for charges for convenience items, including television, telephone, guest beds, etc.; or

29. for breast implants for solely cosmetic reasons; or

30. for sterilization reversal; or

31. In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure; or

32. incurred for, or in connection with, surgery and other services related to sexual impotency; or

33. for contraceptives other than contraceptives covered under the Preventive Care Benefit or the Prescription Drug Benefit; or

34. for abortion; or

35. for paternity testing; or

36. for home uterine activity monitoring devices; or

37. for Cosmetic services except when performed to correct deformities under the following circumstances:

    a. as a result of a covered accidental Injury or Illness; or
    b. repair as a result of congenital abnormalities and hereditary complications or conditions, limited to:
       (1) Cleft lip or palate.
       (2) Birthmarks on head or neck.
       (3) Webbed fingers or toes.
       (4) Supernumerary fingers or toes; or
    c. for reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance; or
    d. for reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

    For purposes of this exclusion, “cosmetic” means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.

38. for routine x-rays or laboratory examinations, including dental x-rays, unless required in connection with services needed to correct damage caused by an Accidental Injury or except for those expressly allowed under the Preventive Care benefit; or

39. for routine physical examinations and well child care, including related diagnostic testing unless the service is specifically listed as eligible in the Schedule of Benefits; or

40. for dental services, dental prostheses and dental x-rays, unless specifically listed in the Schedule of Benefits or Covered Medical Expenses; or

41. for treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for treatment of injury to Sound Natural Teeth due to an accident [and pediatric dental benefits specifically listed under Covered Medical Expenses]; or

42. in connection with the prevention or correction of malocclusion of the jaws by wire braces or any other treatment unless specifically listed in the Schedule of Benefits; or

43. for examinations, testing, and procedures related to vision correction, including eye glasses and contact lenses unless specifically listed in the Schedule of Benefits; or

44. for laser or radial keratotomies; or

45. for examination, testing, and procedures related to hearing correction, including hearing aids; or

46. for care for corns, calluses, bunions, or toenails except for related Surgical Procedures; or

47. for hair replacement or removal; or

48. for travel, whether or not recommended by a Physician; or

49. for pre-marital or pre-employment examinations including all related diagnostic testing; or

50. for marriage counseling; or

51. all food, formula, vitamins, and nutritional supplements, or except as provided for under Covered Medical Expenses for Parenteral and Enteral nutrition; or

52. for routine treatment of obesity or services primarily for weight loss or control, unless necessitated as the direct result of a specifically identifiable and diagnosed condition or disease etiology; or

53. benefits in excess of 1 per lifetime for and related in any way to weight loss surgery, gastric bypass surgery, bariatric surgery, stomach stapling surgery, open/laparoscopic Roux-en-Y- gastric bypass (RYGB), Vertical Banded Gastroplasty (VBG), Laparoscopic Adjustable Silicone Gastric Banding (LASGB or Lap-Band), or similar surgeries or procedures; or

54. Benefits for and related in any way to weight loss surgery, gastric bypass surgery, bariatric surgery, stomach stapling surgery, open/laparoscopic Roux-en-Y-gastric bypass (RYGB), Vertical Banded Gastroplasty (VBG), Laparoscopic Adjustable Silicone Gastric Banding (LASGB or Lap-Band), or similar surgeries or procedures that do not meet the requirements listed in Covered Medical Expenses; or

55. for a prescription drug charge that is not eligible under the agreement between the Network prescription provider and Company;

56. for charges for replacement, repair, or maintenance of durable medical equipment or prosthetic devices or orthotics unless specifically listed as covered elsewhere; or

57. for bio-feedback training; or

58. for music therapy or reading therapy; or

59. for hypnotherapy; or

60. for recreational therapy, including cognitive rehabilitation; or

61. for occupational therapy, except when Confined or in conjunction with Outpatient physical therapy; or

62. for educational training or testing; or

63. for any Cardiac Rehabilitation procedure that is not specifically listed as a Covered Medical Expense; or

64. for maintenance or unsupervised programs, or the purchase or rental of exercise equipment in connection with Cardiac rehabilitation; or

65. for any human organ or bone marrow transplant procedure that is not specifically listed as eligible under Covered Medical Expenses, or that is performed Out-of-Network

66. for charges associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy and includes an automobile insurance deductible; or

67. in connection with a newborn child of a Dependent daughter; or

68. for a donor's expenses in connection with an organ transplant; or

69. for benefits that are available to the Insured through any extension or continuation of benefits provision of any prior group health policy or group health plan or program of the Insured; or

70. for expenses covered or provided for by the U.S. Social Security Act; or

71. for Phase II irreversible treatment for Temporomandibular Joint and Comparable disorders. Irreversible treatment includes but is not limited to; equilibration of occlusion, coronoplasty, occlusal adjustment; slides and/or photographs; non-prescription drugs, vitamin, nutrition supplements; stretching and other exercises; coolant sprays; moist heat therapy; hot packs; massage, either manual or by machine; acupuncture; cold packs; range of motion treatments; diet survey; nutritional counseling; rent or purchase of transcutaneous electrical nerve stimulators; office visits; periapical bitewing and full-mouth radiographs.

72. Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine auto injections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.

73. Services for remedial education, education testing or training (including intelligence testing), or classes covering such subjects as stress management, parenting, and lifestyle changes.

74. Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy.

75. Services provided by a member of the Insured's immediate family; provided by a person who normally lives in the Insured's home; or which are custodial/maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.

76. Charges made by an Assisted Living Facility.

77. For any Covered Medical Expenses which require Prior Authorization and were obtained without a Prior Authorization.

SECTION 7. CLAIM AND APPEAL PROVISIONS

The Company will initially determine if a claim is to be allowed or denied (adverse benefit determination). The Company shall retain final discretionary authority for all benefit determinations and questions of Policy interpretation subject to the Insured's right to an external review by the Director of Insurance and /or a registered Independent Review Organization. This provision applies only where the interpretation of this Policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Company or the Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Company reserves the right to have an Insured seek a second medical opinion.

Following is a description of how the Company processes Claims for benefits. A Claim is defined as any request for a benefit, made by a claimant or by a representative of a claimant, that complies with the Company's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Third Party Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non- urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Company applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	24 hours
Insufficient information on the Claim, or failure to follow the Policy's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information,

including the Company's benefit determination on review, may be transmitted between the Company and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim
A Pre-Service Claim means any Claim for a benefit under this Policy where the Policy conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination

15 days
Extension due to matters beyond the control of the Company

15 days
Insufficient information on the Claim:
Notification of

15 days
Response by claimant

45 days
Notification, orally or in writing, of failure to follow this Policy's procedures for filing a Claim

5 days

Ongoing courses of treatment:

Reduction or termination before the end of the treatment

15 days
Request to extend course of treatment

15 days
Review of adverse benefit determination

30 days
Reduction or termination before the end of the treatment

15 days

Request to extend course of treatment

15 days

Post-Service Claim
A Post-Service Claim means any Claim for a Policy benefit that is not a Claim involving Urgent Care or a Pre- Service Claim; in other words, a Claim that is a request for payment under the Policy for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:
Notification to claimant of benefit determination

20 days
Extension due to matters beyond the control of the Company

15 days
Extension due to insufficient information on the Claim

15 days
Response by claimant following notice of insufficient information

45 days
Review of adverse benefit determination

60 days

GRIEVANCE PROCEDURES

If the Insured has a grievance with the Company or its Third Party Administrator,

a. Call the Company at [800-211-1534], or
b. Contact the Company in writing:
[Claim Manager, Grievances, Appeals and Complaints US Health and Life Insurance Company
8220 Irving Road
Sterling Heights, MI
48312 Fax:
586-693-4820]

The Insured has the following rights:

Notice to Insured

Upon the Insured's notice of a grievance, the Company shall provide timely, adequate, and appropriate notice to each Insured Person of:

1. The grievance procedure required under Indiana law;
2. The external grievance procedure required under Indiana law;
3. information on how to file a grievance and a request for an external grievance review permitted under Indiana law; and
4. A toll free telephone number through which an Insured may contact the Company at no cost to the Insured to obtain information and to file grievances.

The information will include the toll free telephone number and the address at which a grievance or request for external grievance review may be filed with the Company.

Filing of Grievance

1. The Insured may file a grievance orally or in writing.
2. The Company shall make available to the Insured a toll free telephone number through which a grievance may be filed. The toll free telephone number will be staffed by a qualified representative of the Company, available for at least forty (40) hours per week during normal business hours, and accept grievances in the languages of the major population groups served by the Company.
3. A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

Resolution of grievances

1. The Company has established written policies and procedures for the timely resolution of grievances including:
   A. An acknowledgment of the grievance, given orally or in writing, to the Insured within five (5) Business days after receipt of the grievance.
   B. Documentation of the substance of the grievance and any actions taken.
   C. An investigation of the substance of the grievance, including any aspects involving clinical care.
   D. Notification to the Insured of the disposition of the grievance and the right to appeal.
   E. Standards for timeliness that accommodate the clinical urgency of the situation will include responding to grievances and providing notice to the Insured of the disposition of the grievance and the right to appeal.

2. The Company shall appoint at least one (1) individual to resolve a grievance.

3. A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the Company receive all information reasonably necessary to complete the review. If the Company is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond its control, the Company shall:
   A. Before the twentieth business day, notify the Insured in writing of the reason for the delay; and
   B. Issue a written decision regarding the grievance within an additional ten (10) business days.

4. The Company shall notify the Insured in writing of the resolution of a grievance within five (5) Business days after completing an investigation. The grievance resolution notice must include the following:

A. A statement of its decision.
B. A statement of the reasons, policies, and procedures that are the basis of the decision.
C. Notice of the Insured's right to appeal the decision.
D. The department, address, and telephone number through which the Insured may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Resolution of appeals of grievance decisions

1. The Company or the Third Party Administrator has established written policies and procedures for the timely resolution of appeals of grievance decisions including:
   A. Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.
   B. Documentation of the substance of the appeal and the actions taken.
   C. Investigation of the substance of the appeal, including any aspects of clinical care involved.
   D. Notification to the Insured of the disposition of an appeal and that the Insured may have the right to further remedies allowed by law.
   E. Standards for timeliness that accommodate the clinical urgency of the situation will include responding to the appeal, providing notice to the Insured of the disposition of an appeal and the right to initiate an external grievance review.

2. In the case of an appeal of a grievance decision described herein, the Company shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one
   (1) or more individuals who:
   A. have knowledge of the medical condition, procedure, or treatment at issue;
   B. are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
   C. are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and
   D. do not have a direct business relationship with the Insured or the health care provider who previously recommended the health care procedure, treatment, or service-giving rise to the grievance.

3. An appeal of a grievance decision must be resolved:
   A. as expeditiously as possible, reflecting the clinical urgency of the situation; and
   B. not later than forty-five (45) days after the appeal is filed.

4. the Company shall allow the Insured the opportunity to appear in person before or, if unable to appear in person, otherwise appropriately communicate with the panel appointed under subsection 2. above.

5. The Company shall notify the Insured in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:
   A. A statement of the decision reached by the Company or its Third Party Administrator.
   B. A statement of the reasons, policies, and procedures that are the basis of the decision.
   C. Notice of the Insured's right to further remedies allowed by law, including the right to external grievance review by an independent review organization.
   D. The department, address, and telephone number through which the Insured may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make a payment, (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

1. a determination of an individual's eligibility to participate in a Plan or health insurance coverage;
2. a determination that a benefit is not a covered benefits;
3. the imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
4. a determination that a benefit is experimental, investigation, or not medically necessary or appropriate; or
5. a rescission of coverage.

An adverse benefit determination applies to pre-service claims and post-service claims.

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Third Party Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific Policy provisions on which the determination was based.

3. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

4. A description of the Company's review procedures, incorporating any voluntary appeal procedures offered by the Company and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of this Policy to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

8. The notice will be in a culturally and linguistically appropriate manner and provide the claimant with the available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman established
to assist with the appeals processes.

The Plan will provide, free of charge, any new or additional evidence considered for the adverse benefit determination. It will be provided as soon as reasonably possible and sufficiently in advance of the date of the notice of adverse benefit determination on review to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the Company can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided with, free of charge, the rationale. The rationale will be provided as soon as reasonably possible and sufficiently in advance of the date of the notice of adverse benefit determination on review to give the claimant a reasonable opportunity to respond prior to that date.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision. To prevent conflicts of interest, decisions regarding hiring, compensation, termination, promotion and similar matters with respect to any individual — such as a claim adjudicator or medical expert — cannot be based upon the likelihood that the individual will support the benefit denial.

If the Plan fails to strictly adhere to all of the requirements of the internal claims and appeals processes with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, and is permitted to initiate external or judicial review.

External Grievance Procedural requirements

1. An external grievance procedure established under Indiana law must:
   A. Allow the Insured or the Insured's representative to file a written request with the Company for an external grievance review of Our appeal resolution or denial of coverage based on a waiver not more than 120 days after the Insured is notified of the resolution; and
   B. Provide for an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the Insured’s life or health or ability to reach and maintain maximum function or a standard external grievance review for a grievance not described herein.

   The Insured may file not more than one (1) external grievance of our appeal resolution under section.

2. Subject to the requirements of subsection (d), when a request is filed under subsection (a), the Company shall:
   A. Select a different independent review organization for each external grievance filed herein from the list of independent review organizations that are certified by the Insurance department; and
   B. Rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

3. The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

4. The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

   A. The Company.
   B. Any officer, director, or management employee of the Company.
   C. The health care provider or the health care provider's medical group that is proposing the

service.
D. The facility at which the service would be provided.
E. The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.
F. The Insured Person requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to the Insured and the Company or the Third Party Administrator may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the Insured and the Company or the Third Party Administrator before commencing the review and neither the Insured nor the Company object.

5. The Insured shall not pay any of the costs associated with the services of an independent review organization. All costs must be paid by the Company.

Rights and duties

1. An Insured who files an external grievance under the policy shall:
   A. Not be subject to retaliation for exercising the Insured's right to an external grievance under the policy;
   B. Be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
   C. Be permitted to submit additional information relating to the proposed service throughout the review process; and
   D. Cooperate with the independent review organization by providing any requested medical information or authorizing the release of necessary medical information.

2. The Company shall cooperate with an independent review organization selected by promptly providing any information requested by the independent review organization.

Determination by review organizations

1. An independent review organization shall:
   A. For an expedited external grievance filed under the policy, within seventy-two (72) hours after the external grievance is filed; or
   B. For a standard appeal filed under the policy, within 15 business days after the appeal is filed;
   C. Make a determination to uphold or reverse the Company's appeal resolution based on information gathered from the Insured or the Insured's designee, the Company, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

2. When making the determination, the independent review organization shall apply:
   A. Standards of decision making that are based on objective clinical evidence; and
   B. The terms of the Insured's accident and sickness insurance policy.

3. In an external grievance described above, the Company bears the burden of proving that the Company properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived.

4. The independent review organization shall notify the Company and the Insured of the determination made under this section:
   A. For an expedited external grievance filed under the policy, within seventy-two (72) hours after the external grievance is filed; and
   B. For a standard external grievance filed under the policy, within 72 hours after

making the determination.

The decision of the independent review organization is binding on the Company and its Third Party Administrator.

Submission of new information

1. If, at any time during an external review performed under this policy, the Insured submit information to the Company or its Third Party Administrator that is relevant to the Our resolution of the Insured's appeal of a grievance decision and that was not considered by the Company under the internal grievance procedures:

   A. the Company may reconsider the resolution; and
   B. if the Company chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

2. The Company shall reconsider the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution based on the information and notify the Insured of Our decision within 72 hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the Insured Person's life or health or ability to reach and maintain maximum function or within 15 days after the information is submitted, for a reconsideration not described above.

3. If the decision reached under subsection 2. is adverse to the Insured, the Insured may request that the independent review organization resume the external review under the policy.

4. If, per the information which is submitted to the Company or its Third Party Administrator under subsection 1. A above, the Insured chooses not to reconsider Our resolution, the Company shall forward the submitted information to the independent review organization not more than two business days after the Company's receipt of the information.

Grievance means any dissatisfaction expressed by or on behalf of the Insured regarding:

1. a determination that a service or proposed service is not appropriate or medically necessary;
2. a determination that a service or proposed service is experimental or investigational;
3. the availability of participating providers;
4. the handling or payment of claims for health care services; or
5. our decision to rescind this contract; or
6. a determination concerning a prior authorization request under IC 27-1-37.5 and for which the Insured has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

NOTICE

Questions regarding your policy or coverage should be directed to:

US Health and Life Insurance Company [1-800-211-1534]

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of
Insurance [Consumer Services
Division
311 WEST Washington Street,
Suite 300 Indianapolis, IN 46204]

[Consumer Hotline: (800) 622-4461; (317) 232-2395]
Complaints can be filed electronically at [www.in.gov/idoi].

SECTION 8. STANDARD PROVISIONS

Entire Contract; Changes
This policy, including the applicable riders and endorsements; the application for coverage if specified by the insurer; the identification card if specified by the insurer; and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on this policy or attached to this policy. An insurance producer does not have authority to change this policy or to waive any of its provisions.

Time Limit On Certain Defenses
After 2 years from the effective date of coverage no misstatements, except fraud or intentional misrepresentation of material fact, made by the applicant in the application for coverage shall be used to void the coverage or to deny a claim for loss incurred or disability commencing after the end of the 2-year period. We must provide 30 days' notice of rescission or termination of coverage to any person affected. The notice will include the reason for rescission or termination. This policy does not have a pre-existing condition exclusion.

Reinstatement
If the premium is not paid during the grace period, this contract will be cancelled. To re-enroll you must have a triggering event for a Special Enrollment opportunity or wait for the next Open Enrollment.

Conformity with Applicable Law
Any provision of the Policy which, on its effective date, is in conflict with an applicable federal law, is amended to conform with the minimum requirements of that law.

If You Receive Covered Health Services from a Network Provider
We pay Network providers directly for your Covered Medical Expenses. If a Network provider bills you for any Covered Medical Expenses, contact us. However, you are responsible for meeting any applicable 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.

If You Receive Covered Health Services from a Non-Network Provider
This Policy does NOT pay benefits for Covered Medical Expenses from a non-Network provider, except for an Emergency or if we refer you to a Non-Network provider. You are responsible for requesting payment from us. You must file the claim in a format that contains all the information we require, as described below.

Notice of Claim
Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or beneficiary to Us, or to any of Our authorized agents with information sufficient to identify the Insured, shall be deemed notice to Us.

Proof of Loss
Written proof of claim must be given to the Company within 90 days from the date the expense was incurred or as soon as is reasonably possible.

After receipt of a written notice of claim, the Company will furnish the claimant with forms for filing a proof of claim. If the forms are not furnished within 15 days after the written notice of claim was filed, the claimant shall be deemed to have complied with the requirement for filing proof of claim by virtue of having filed the written notice of claim.

Written proof of claim must be given to the Company by the end of the Plan Year following the Plan Year in which the expense was incurred. However, when the Insured's coverage terminates for any reason,

written proof of claim must be given to the Company within 60 days of the date of termination of coverage, provided that the Policy remains in force. Claims will be paid on a timely basis by the Company upon receipt of complete written proof. Upon termination of the Policy, final claims must be received within 30 days of termination.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was given as soon as was reasonably possible but no later than 1 year from the time proof of claim is otherwise required.

For charges that are applied to satisfy a Deductible amount, the date of loss shall mean the date when the sum of the charges equals the Deductible amount. For other charges, the date of loss shall mean the date the charge is incurred.

In the event that a claim is denied, and the Insured appeals said denial, the Company shall not be obligated to pay any part of said claim until a final determination has been made under the claims appeal procedure.

The Company shall have the right (at its own expense) to require a claimant to undergo a physical examination when and as often as may be reasonable.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

1. The Policyholder's name and address.
2. The patient's name and age.
3. The number stated on your ID card.
4. The name and address of the provider of the service(s).
5. The name and address of any ordering Physician.
6. A diagnosis from the Physician.
7. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
8. The date the Injury or Sickness began.
9. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

[Name
Address
City, ST Zip]

Payment of Any Claim

Payment of any claim will be made to the person rendering the services, unless the Insured furnishes paid receipts with his proof of claim. If the Insured dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Insured or to any person or corporation appearing to the Company to be entitled to payments. The Company shall discharge its liability by such payments.

Time of Payment of Claims

Claims made for indemnities provided under the Policy shall be deemed payable immediately upon receipt of due written proof of loss.

Claims Appeal

If a claim is denied in whole or in part, the Insured will receive written notification of the decision. An explanation of benefits worksheet will be provided by the Company showing the calculation of the total

amount payable, charges not payable, and the reason why they are not payable. An Insured may request a review by filing a written application with the Company who will then review the claim and furnish copies of all documents and all reasons and facts relating to the decision. The Insured may then formally appeal the decision by filing a written request to the Company stating their opinion of the issues and other comments. This appeal must be submitted within 60 days of the receipt of written notice of denial. The Company will issue a decision within 60 days of receipt of the Insured's written request unless special circumstances require an extension. The decision of the Company shall end the appeal procedure under the Company.

Physical Examination and Autopsy
The Company, at its own expense, shall have the right and opportunity to have the person or any individual whose Injury or Illness is the basis of a claim, examined by a Physician designated by it, when and as often as it may reasonably require during the pendency of a claim under the Policy and to make an autopsy in case of death, where it is not forbidden by law.

Legal Action
No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 5 years after the time written proof of loss is required to be furnished.

Workers' Compensation
This Policy is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

Genetic Testing
Coverage is not limited based on genetic testing. We will not adjust premiums, request or require genetic testing, or collect genetic information from an individual at any time for underwriting purposes.

SECTION 9. COORDINATION OF BENEFITS WITH OTHER COVERAGE

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

A. Definitions

1. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    a. Plan includes:
        (1) group insurance and subscriber contracts
        (2) nongroup insurance contracts effective on or after January 1, 2014
        (3) health maintenance organizations (HMO) contracts
        (4) closed panel or other forms of group or group-type coverage (whether insured or uninsured)
        (5) medical care components of long-term care contracts, such as Skilled Nursing Care
        (6) Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include:
        (1) hospital indemnity coverage or other fixed indemnity coverage
        (2) accident only coverage
        (3) specified disease or specified accident coverage
        (4) benefits for non-medical components of long-term care policies
        (5) Medicare supplement policies
        (6) Medicaid policies
        (7) coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under a or b above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering the person. When a plan

provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

a. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

c. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

2. a. Except as provided in Paragraph (b), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of- network benefits.

3. A plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each plan determines its order of benefits using the first of the following rules that apply:

a. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other plan is the primary plan.

b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(a) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
(a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's heath care expenses or health care coverage, the provisions of item (1) above shall determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of item (1) above shall determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
(i) The plan covering the custodial parent;
(ii) The plan covering the spouse of the custodial parent;
(iii) The plan covering the noncustodial parent; and then
(iv)The plan covering the spouse of the noncustodial parent.

(3) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of item (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the

other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled B.4.a can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled B.4.a can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

f. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

C. Effect on the Benefits of this Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amount it would have credited to its Deductible in the absence of other health care coverage.

2. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. Facility of Payment

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

F. Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid;

or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.