US Health and Life Insurance Company
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.

Once an Insured is stabilized following an emergency service, We require as a condition of further coverage that a hospital emergency facility promptly contact Us for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other medically necessary and appropriate care for an Insured.

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

In accordance with the requirements of WHCRA and K.S.A. 40-2,166 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.

"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, children under court appointed guardianship, children placed for adoption and legally adopted children are eligible from the date the child becomes a stepchild, the date you are appointed guardian by the court, the date the child is placed with the you for 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 Health Condition” means a mental disease or disorder or a functional nervous disorder defined as such in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

"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 p rofessional 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" 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) or Dependents 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.

b. 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.

c. 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 shall be computed pro rata 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. (BHP is only available in Minnesota and New York.)
   g. Dependents who no longer qualify under the general definition of Insured.

C. Cancellation by insured.

The Insured may cancel this policy at any time by written notice delivered or mailed to Us, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or death of the insured, the insurer will promptly return the unearned portion of any premium paid. The earned premium shall be computed pro rata where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

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 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 variecella and other vaccines and dosages as may be prescribed by the Kansas Secretary of Health and Environment.

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.

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 “Member of Your Household”.
(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. Semi-Private Room and Board;
2. Other services and supplies ordered by a Physician and furnished by the Skilled Nursing Facility for Inpatient medical care; or
3. 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; and
9. Treatment must be rendered in an approved facility by an M.D., Ph.D., or licensed Social Worker.

KK. Treatment for Substance Abuse.

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.

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 for urinary incontinence in adults 18 years old and older.

JJJ. Spinal Manipulative Services.

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. 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). Up to three sets of lenses per calendar year;
3. Three pairs of frames every calendar year. Standard frames include a minimum one year warranty. For non-standard frames, Insured is responsible for the entire expense of the frames.

WWW. Blepharoplasty of upper lid.

XXX. Breast reduction.

YYY. Surgical treatment of male gynecomastia.

ZZZ. 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.

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 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
Benefits are not provided for:

1. Charges to administer or inject any drug.
2. Prescription Drugs that are administered or entirely used up at the time and place ordered.
3. Prescription Drugs for which normally (in professional practice) there is no charge.
4. Prescription Drugs for other than human use.
5. Orthopedic or prosthetic appliances and devices.
6. Prescription Drugs purchased from an institutional pharmacy for use while the Insured is an Inpatient in that institution.
7. Charges for delivering any drugs.
8. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
9. Drugs, supplies, and equipment used in intravenous treatment.
10. Benefits are not available to the extent a Prescription Drug has been covered under another contract, policy, or rider issued by US Health and Life Insurance Company.
11. Allergy antigens.
12. Any food item, including breast milk, formulas and other nutritional products.
13. Total parenteral nutrition.
14. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order under federal or state law.
15. Charges for services that are not listed as covered services.
16. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
17. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Policy will provide coverage

on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.

18. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
19. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
20. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
21. Services that are not Medically Necessary, as defined in this Policy.
22. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
23. Charges for completion of insurance claim forms.
24. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
25. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
26. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
27. Appetite suppressants.
28. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.
29. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
30. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
31. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Policy.
32. Vaccines and Immunizations.

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

Benefits will not be provided for:

1. Services that are not listed as covered services.

2. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a non-specified provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.

3. Services in which duplicate benefits are available under federal, state, or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. Coverage will be provided on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.

4. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

This exclusion applies whether or not You choose to waive Your rights to these services.

5. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.

6. Services that are not Medically Necessary, as defined in this policy.

7. Services that are determined not to be medically necessary through the hospital's Utilization Review process. In the absence of a hospital Utilization Review process, the Company has the right to determine when services are medically unnecessary.

8. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.

9. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.

10. Procedures and diagnostic tests that are considered to be obsolete by the Company's professional medical-advisory committee.

11. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.

12. Services that are already covered under another provision of this policy.

13. Blood or payment to blood donors.

14. Any service or supply associated with the medical management and treatment of obesity. This includes but is not limited to surgery, office visits, hospitalizations, laboratory or radiology services, prescription drugs, medical weight reduction programs, nutrients and diet counseling.

15. Inpatient Skilled Care, Intermediate Care, Convalescent Care, Custodial/Maintenance Care or Rest Cures.

16. All services associated with transplant procedures except those specifically set out as benefits.

17. Services associated with any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screenings are mobile vans and school testing programs.

18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.

19. Acupuncture.

20. Services or supplies associated with sex changes/gender reassignment, and services related to sexual function, and any related complications.

21. Reversal of sterilization procedures.

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

23. Charges for autopsies, unless the autopsy is requested by US Health & Life Insurance Company.

24. Transportation other than covered Ambulance Services.

25. Charges for completion of insurance claim forms.

26. Laboratory services performed by an independent laboratory that is not approved by Medicare.

27. Prescription drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.

28. Cosmetic or reconstructive surgery except when the surgical procedure is one of the following:

a. Cosmetic or reconstructive repair of an Accidental Injury.

b. 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.

c. Repair 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.

d. 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 provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.

29. Refractive procedures including; radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.

30. All services associated with Temporomandibular Joint Dysfunction Syndrome except those services specifically set out as benefits.

31. Health services 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. The excluded expenses cannot be used for any purpose under this policy.

32. Automatic external defibrillators.

33. Institutional Provider services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis, or internet access.

34. Professional Provider services or charges for:

a. Services where the Provider would normally make no charge.

b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision, electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

c. Services by an immediate relative or member of Your household. "Immediate relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

d. Repair or replacement of dental plates and all dental care other than that listed as a covered service.

e. Hearing aids; servicing of visual corrective devices, or consultations related to such services; orthoptic and visual training.

35. Any service associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this policy.

36. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education.

37. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

38. Any food item including breast milk, formulas and other nutritional products.

39. Appetite suppressants.

40. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.

41. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this policy; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.

42. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

43. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.

44. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

45. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

46. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Insured failing to complete the initial treatment plan.

47. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.

48. Any device used for enhancing or enabling communication except for an electrolarynx.

49. Services provided for a Mental Illness or Substance Use Disorder by a provider that is not an Eligible Provider for Mental Illness or Substance Use Disorders.

50. Non medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

51. Services of volunteers.

52. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.

53. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.

54. Services for or related to elective abortions.

For purposes of this provision, "elective" means as follows: for any reason other than to prevent the death of the mother upon whom such services are performed, except that it includes those services based on a claim or diagnosis that the mother shall or may engage in conduct likely to result in her death.

For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

SECTION 7. CLAIM AND APPEAL PROVISIONS

This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the Company to afford Insureds a full and fair review of Claim decisions and Appeal decisions as described in this contract.

However, an Insured's rights accrued hereunder or under applicable state or federal law (including but not limited to ERISA) are not assignable to any person or entity. Authorized Representatives may be designated as provided in section A below.

A. Definitions

For the purpose of this Appeal Procedures section, the following terms and their definitions apply:

Adverse Determination:
A determination by a URO made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Independent (External) Review: A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate, experimental/investigational. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

Life Threatening: A disease or condition for which the likelihood of death is probable unless the course if the disease or condition is interrupted.

Same/Similar Specialist Review: Review by a health care practitioner who has appropriate training and experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems or sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

B. Procedure:

Appeals of Prospective, Concurrent and Retrospective Adverse Determinations

An enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal and adverse determination orally or in writing.
An appeal acknowledgement letter will:

A. be sent to the appealing party within five (5) working days from receipt of the appeal;
B. include acknowledgement of the date of the Plan's receipt of the appeal;
C. include a list of relevant documents needed to be submitted by the appealing party to the Plan;
D. include a one-page appeal form to be completed by the appealing party when the appeal of an adverse determination was received orally for review of the appeal Adverse Determination Appeal Process includes the following:
    1. Appeal decisions are made by a physician who has not previously reviewed the case.
    2. The physician or provider involved in the appeal review is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment as well as treating similar complications of those conditions. Depending on the type of case, a same or similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner as appropriate. Their training and experience will be sufficient for the specialist to determine if the services or

procedure is medically necessary or clinically appropriate, to include having training to treat the condition and treating complications that may result from the service or procedure. In cases where the Plan does not have a Medical Director that is a same or similar specialty, the case is referred to a contracted same or similar specialist. The Plan will include a list of titles and qualifications, including specialties, of individuals participating in the appeal review.

Specialties include, but are not limited to:		
• Cardiology	• Neurology	• Pediatrics
• Chiropractic	• Neurosurgery	• Podiatry
• Dermatology	• OB/GYN	• Psychiatry
• Emergency Medicine	• Oncology	• Pulmonology
• Family Practice	• Ophthalmology	• Radiology
• Gastroenterology	• Orthopedics	• Surgery
• Internal Medicine	• Otolaryngology	• Urology

The physician or provider performing the appeal review will attest that he/she is licensed or certified in a field that typically manages the clinical issue under review and has current and relevant knowledge and/or experience to render a determination for the case that he/she is reviewing on appeal.

3. The physician or provider reviewing the appeal may interview the enrollee or the enrollee's designated representative.
4. Provide an opportunity for the enrollee and his or her representative to examine the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered during the appeal process. This information will be provided free of charge and sufficiently in advance of the resolution time frame for appeals.
5. If the appeal decision involves medical necessity or appropriateness, or the experimental or investigational nature of the health care services prior to issuance of an adverse determination, the Plan will offer the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with the Plan Medical Director. The discussion at a minimum includes the clinical basis for the decision.

Expedited Appeal:
Expedited appeal process includes denial for emergency care, life threatening conditions, continued stays for hospitalizations, denial of prescription drugs or intravenous infusions for which the patient is receiving benefits and an expedited appeal for a denied step therapy protocol exception request.

A. An expedited appeal is reviewed by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review.
B. Expedited appeals are completed based on the medical immediacy of the condition, procedure, or treatment and will not exceed one working day from the date all information necessary to complete the appeal has been received. The Plan will provide a response by telephone or electronic transmission and will be followed by a letter within three working days of the initial telephonic or electronic notification.

Resolution Letters for Adverse Determination or Expedited Appeals

Upon determination of the appeal the Plan will issue a letter to the enrollee, person acting on behalf of the enrollee, or the enrollee's physician or health care provider of record explaining the resolution of the appeal. This letter will include the following:

- A statement of the specific medical or contractual reasons for the resolution;
- The clinical basis for the decision;
- A description of or the source of the screening criteria that were used in making the determination
- The professional specialty of the physician who made the determination
- Notice of the appealing party's right to seek review of the adverse determination by an external review and the procedures for obtaining that review.
- A copy of the form to request an external review
- Procedures for filing a complaint related to utilization review process

Written notification to the appealing party of the determination of the appeal will be completed as soon as practical, but in no case later than 30 days after the date the Plan received the written appeal or the one-page appeal form.

In a circumstance involving an enrollee's life-threatening condition, denials of prescription drugs and intravenous infusions that are currently being received, or if the Plan's internal appeal process timelines are not met, the enrollee is entitled to an immediate appeal to an external review and is not required to comply with procedures for an internal review the adverse determination.

Timeline to file an appeal:
Preservice: 180 days from date of receipt of the Adverse Benefit Determination Notice
Post Service: 180 days from date of receipt of the Adverse Benefit Determination Notice

Timeline for Resolution:
Preservice Urgent: 48 hours
Preservice (non-urgent): 15 days
Post-Service: 30 days

EXTERNAL REVIEW OF ADVERSE DETERMINATION:
The Plan will permit a member who has a life-threatening condition, or if the Plan's internal appeal process timelines were not met, or has completed the internal adverse determination appeals process and the appeal resulted in a denial by the Plan, to seek review of that determination by the ER as follows:

1. The Plan will provide a notification to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record, on how to appeal the denial of an internal appeal to the ER. The notification shall describe how to obtain independent review of such determination and, include the form requesting enrollee information.
2. The Plan will provide the notification and the form prescribed by the ER to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record at the time of denial of the appeal
3. The form will be completed by the enrollee, person acting on behalf of the enrollee or the enrollee's provider of record and returned to the Plan to begin the independent review process. The form prescribed by the ER authorizing release of medical information to the ER must be signed by the enrollee or the enrollee's legal guardian.
4. The enrollee, or person acting on behalf of the enrollee, may file a request for ER within 4 months after a notice of an adverse determination.
5. The Plan must provide all documents and information related to the denial and initial appeal to the ER within 5 business days.
6. The enrollee, or person acting on behalf of the enrollee may also submit any additional information they want to the ER to consider during the review.
7. For a standard (non-urgent) review, the examiner must provide written notice of the final external review decision as expeditiously as possible and no later than 30 days after the examiner receives

the request for the external review. The enrollee, or person acting on behalf of the enrollee will receive review determinations in writing from the Plan.

8. For urgent care situations, the enrollee, or person acting on behalf of the enrollee, may file an expedited review for an adverse determination if:
    a. For an expedited external review, the examiner must provide notice of the final external review decision to the Plan UM as expeditiously as the medical circumstances require and within 48 hours once the examiner receives the request for the external review. The Plan must deliver the notice of final external review decision to the enrollee, or person acting on behalf of the enrollee. This notice can be initially provided orally but must be followed up in writing within 48 hours.
9. The examiner has no direct financial interest in the organization or in the outcome of the independent review. May not have been involved in the original determination under appeal.

The Plan will comply with the ER's determination with respect to the medical necessity, appropriateness or experimental or investigational nature of health care items and services for an enrollee.

The Plan will be responsible for any charges that may be incurred for the external review.

C. Procedure for Pursuing an External Review – Kansas Department of Insurance

Members may request External Review of Adverse Health Care Decisions through Kansas Department of Insurance:

1. The Insured has the right, to request an External Review of an Adverse Decision Eligible for External Review after an Appeal (where applicable) has been completed or when the Insured has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Insured. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, such request may be made before the Insured has exhausted all the other available review procedures. The Plan will notify the Insured in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

2. Within 4 months of receipt of the notice of a final Adverse Decision, the Insured, the treating physician or health care provider acting on behalf of the Insured with written authorization from the Insured, or a legally authorized designee of the Insured must make a written request for an External Review to the Kansas Insurance Commissioner, at the Kansas Insurance Department, 1300 SW Arrowhead Road, Topeka, KS 66604, (785) 296-3071 or (800) 432-2484.

3. Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Commissioner will notify the Insured and other involved parties as to whether the request for External Review is granted.

4. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Insured and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this contract.

5. The decision of the External Review Organization may be reviewed directly by the district court at the request of either the Insured, insurer or health insurance plan. The review by the district court shall be de novo. The decision of the External Review Organization shall not preclude the Insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the Insured,

insurer, or health insurance plan after the decision of the External Review Organization will not stay the External Review Organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an External Review and the decision of the External Review Organization as a result of the External Review shall be deemed admissible in any subsequent litigation.

The right to External Review shall not be construed to change the terms of coverage under this contract. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

D. Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the Appeal of an Adverse Decision, whether or not You pursue External Review. However, in the case of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, no Appeal is necessary and only completion of the External Review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

E. Strict Adherence by the Plan

If for any reason the Plan fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Plan asserts it substantially complied with appeals procedures or committed any de minimis error.

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.

No claim for loss incurred or disability commencing after two years from the date of issue of this policy will be reduced or denied on the grounds that a disease or physical condition existed prior to the effective date of coverage of this policy. This policy contains no pre-existing conditions.

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.

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:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- 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.