US Health and Life Insurance Company
Home Office: [800 Tower Drive, Suite 300], [Troy], Michigan [48098]

ASCENSION PERSONALIZED CARE
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 health care provider or facility who participates in the network. If you receive services from an Out-of-Network Provider 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 an In-Network 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]

UTILIZATION MANAGEMENT
NOTICE OF PRIOR AUTHORIZATION REQUIREMENTS

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 the Utilization Management Program 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 the Insured's Identification Card. The Utilization Management phone number is [1-833-600-1311] or [1-844-995-1145].

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.

Case Management

Under certain circumstances, the Policy allows USHL the flexibility to offer benefits for expenses which are not otherwise Covered Expenses. USHL, at its sole discretion, may offer such benefits if:

- The Insured, his family, and the Physician agree;
- Benefits are cost effective; and
- USHL anticipates future expenditures for Covered Expenses which may be reduced by such benefits.

Any decision by USHL to provide such benefits shall be made on a case-by-case basis. The case coordinator for USHL will initiate case management in appropriate situations.

Continuity of Care

In the event an Insured is under the care of an In- Network Provider at the time such provider stops participating in the Network and at the time of the Network Provider's termination, the Insured has special circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving Treatment in accordance with the dictates of medical prudence, USHL will continue providing coverage for that provider's services at the In-Network cost sharing.

If the In-Network Provider is terminated based on reasons relating to medical disciplinary cause or reason, We will not authorize ongoing Treatment with that provider. We will assist the Insured in selecting a new provider in order to continue their ongoing Treatment plan.

Special circumstances means a condition such that the treating Physician or health care provider reasonably believes that discontinuing care by the treating Physician or provider could cause harm to the Insured. Special circumstances shall be identified by the treating Physician or health care provider, who must request that the Insured be permitted to continue Treatment under the Physician's or provider's care and agree not to seek payment from the Insured of any amounts for which the Insured would not be responsible if the Physician or provider were still an In- Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Insured has been diagnosed with a terminal illness, beyond the date the provider's termination from the Network takes effect. However, for Insureds past the 24th week of pregnancy at the time the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

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.

“Accidental Injury” means an unintended injury to Your body caused through external means. “Accidental Injury” does not include: injuries that occur before the date from which You have had continuous coverage with the Company; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.

"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.

“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.

"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.

"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.
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> "Embedded 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. It can be satisfied by any combination of family members, but any one individual cannot contribute more than the Individual Deductible amount. An individual family member may be entitled to benefits before the Family Deductible is satisfied if that family member satisfies the Individual 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 60 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.

“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.

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

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

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

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

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

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

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

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

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

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

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

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

“Mental Illness” means 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 (IC-10).

"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.

"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.

“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(OMFS, OMS);
- Physician Assistant (PA);
- Doctor of Podiatric Medicine (DPM);
- Psychologist and Psychological associates;
- Psychiatrist licensed in the state in which the psychiatrist practices;
- Speech-Language Pathologist..

Physician or Doctor, as defined above, does not include the Policyholder or his Dependents or any person who is the spouse, parent, child, brother or sister of such Policyholder or his Dependents.

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

Primary Care Physician or Doctor means 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.

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

- This Policy
- The Schedule of Benefits.

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. Complications arising during pregnancy include conditions, requiring hospital confinement (when the pregnancy is not terminations, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion , and similar medical and surgical conditions of comparable severity, but does not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications also includes non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. Complications of pregnancy will be treated the same as any other Illness under this Policy.

“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.

“Prior Authorization Review” also referred to as “precertification” or “prior approval” is a process by which Physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage.

“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.

“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 by the Health Insurance Marketplace®.

“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).

“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.

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

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

B. has policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or

more Physicians and one or more Registered Nurses, to govern the skilled nursing care and related medical or other services it provides;

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

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

E. maintains clinical records on all patients;

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

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

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

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

“Sound Natural Tooth” means a tooth that is whole or properly restored; is without advanced periodontal disease and is not in need of the Treatment provided for any reason other than an Accidental Injury.

"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.

“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-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.

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

“Urgent Care” means walk-in care to prevent serious deterioration of an Insured’s health as a result of an unforeseen Illness, Injury, or the onset of acute or severe symptoms or pain which requires immediate Treatment to prevent long-term harm.

“Urgent Care Center” means a facility, not including a hospital emergency room or 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 or pain.

“Worker’s 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.

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.

Eligibility Requirements

Individuals are eligible for coverage under this Policy if, at the time of application, the individual is:

- a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and

- not incarcerated other than incarceration pending the disposition of charges.

Enrollment and Effective Date

In order to enroll or make a change due to any of the events listed below, an eligible 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.

Open Enrollment

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

Effective Dates for All Other Special Enrollment Events

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.

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.

Special Enrollment

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

Eligible individuals may enroll in this QHP or any QHP of their choosing as a result of the following triggering event:

Adding a Dependent or becoming a Dependent through marriage

This applies to the Policyholder, spouse, and any newly-acquired Dependent(s) only. The Policyholder may not change their current QHP due to adding a Dependent.

Eligible individuals and Insureds may enroll in or change from one QHP to another QHP as a result of the following triggering events:

- Loss of minimum essential coverage.
- Adding a Dependent or becoming a Dependent through marriage.
- 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.
- 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.
- 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.
- Becoming newly eligible for advance premium tax credits or cost sharing reductions.
- 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.
- An individual, who was not previously a citizen, national or lawfully present individual gains such status.
- An Indian may enroll in a QHP or change from one QHP to another one time per month.
- Meeting other exceptional circumstances as the Exchange may provide.

Triggering Events Effective on the Date of the Event

Adding a Dependent through birth, adoption or placement for adoption

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.

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

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

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 60 days following birth

Exception: If the petition of adoption is filed after 60 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 60 days following birth

Exception: If a child is placed after 60 days of birth, coverage will be effective the date of placement and provided without charge for 31 days.

Coverage for family members includes delivery and obstetrical expenses at birth for the birth mother of a child adopted by the Insured within 60 days of the birth of such child.

SECTION 3. CANCELLATION

Policyholder Cancellation for on Exchange

The Policyholder 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 Policyholder's request for coverage to be discontinued. In the event of cancellation or death, the earned premium shall be computed pro rata where the Policyholder 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.

Cancellation by the Exchange and/or Company

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 90-day 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 90-day grace period; or

    (2) A grace period of 30 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 last day of the month for which full premium was paid.

c. The Insured's coverage is rescinded in the event of fraud or intentional misrepresentation of a material fact.
d. Discontinuation of this Policy. In this event, We will provide notice of the discontinuance at least 90 days in advance of the termination date. You will also be offered enrollment in other individual policies for which you are eligible. Terminations will be uniformly applied and not based on health status related factors of a covered individual.
e. Withdrawal from the individual market in the State of Kansas. In this event, We will provide notice to You and to the State of Kansas of Our withdrawal from the market at least 180 days prior to Our withdrawal date. Terminations will be uniformly applied and not based on health status related factors of a covered individual.
f. The Insured changes from coverage under this contract to another QHP during an annual open enrollment period or special enrollment period.
g. The Insured is newly eligible for Medicaid or CHIP coverage. Cancellation of coverage will be effective the day before such coverage begins.
h. Dependents who no longer qualify under the general definition of Insured.

Policyholder Cancellation for off Exchange

The Policyholder 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, we will promptly return the unearned portion of any premium paid. The earned premium shall be computed pro rata where the Policyholder resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Reinstatement

If the premium is not paid during the grace period, this contract will be canceled. To re-enroll you must have a triggering event for a Special Enrollment opportunity or wait for the next Open Enrollment. See Section 2 of this Policy for details.

Services Before Coverage Begins or After Coverage Ends

We do not pay for any services, Treatment, care or supplies provided before coverage under this Policy begins or after it ends, unless this Policy states otherwise. If coverage begins or ends while the Insured is an Inpatient in an Acute Care Hospital, our payment will be based on our contract with the hospital. It may cover the following:

- The services, Treatment, care or supplies the Insured receives during the entire admission, or
- Only the services, Treatment, care or supplies the Insured receives while their coverage is in effect.

We may pay for only the services, Treatment, care or supplies the Insured receives while their coverage is in effect if it begins or ends while the Insured is:

- An Inpatient in a facility such as a hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, or other facility identified by Us, or
- Being treated for an episode of Illness by a Home Health Agency, ESRD facility or Outpatient hospital rehabilitation unit or other facility identified by us.

If the Insured has other coverage when a facility admits or discharges them, it may have to pay for the care the Insured receives before the Insured's coverage begins or after it ends with Us.

SECTION 4. MEDICAL BENEFITS

Coverage Provided

Coverage under this Policy becomes effective on the Effective Date indicated on the face page of this Policy.

To receive benefits from your coverage, you must use a Network Provider. However, payment will be made at the In-Network Provider level of benefits for services provided by an Out-of-Network Provider when the services are provided for an Emergency Medical Condition. We will provide you with a list of providers in your location via our website where you can locate an In-Network Provider that is right for you. Visit our website at ascensionpersonlizedcare.com/find-a-doctor.

We have no obligation to advise you of the applicability of additional payment provisions for using an Out-of-Network Provider during the course of authorization prior to service or otherwise. You are responsible for choosing an In-Network Provider.

If Medically Necessary covered services, excluding Emergency Services, are not available through one of our In-Network Providers we will approve a referral to an Out-of-Network Provider and issue payment to the Out-of-Network Provider at the Qualifying Paying Amount (QPA) as defined by Section 102 of the federal No Surprises Act. You will be held harmless for any amount beyond the copayment, deductible, and coinsurance percentage that you would have paid had you received services from an In-Network Provider.

Schedule of Benefits

The Schedule of Benefits provides a list of the Covered Medical Expenses as described in this Policy. It outlines what percentage of those Covered Medical Expenses will be provided when services are incurred by an Insured to the extent those charges exceed any Deductible and/or Copay and/or Coinsurance amounts.

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 all services and supplies for which benefits are available under this Policy which We determine to be Medically Necessary. Charges for services and supplies which We determine are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy the Cost Sharing Maximum.

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, blood and blood products.

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, Physician Specialist, Nurse or Physician Assistant 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. 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.

G. Surgical Procedures including preoperative and postoperative care.

H. 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.

I. 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.

J. 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.

K. Emergency Services 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 Services will be covered, whether the services are rendered by a Network Provider or Non-Network Provider. Emergency Services rendered by a Non-Network Provider will be covered as a Network service.

- The Cost Sharing Maximum for Emergency Services 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 Services. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Services.**

L. For Urgent Care services provided in a Physician's office or at an Urgent Care Center.

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

N. The administration of blood and blood products.

O. 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.

P. 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.

Q. Surgical dressings, casts, splints, trusses; orthotics, braces (including attached corrective shoes) for an Illness or Injury and Medically Necessary foot orthotics 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.

R. 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.

S. 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.

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

U. Imaging (i.e.radiation therapy, MRI, CT/PET Scans) and Treatments with other radioactive substances.

V. 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.

W. 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.

Speech therapy is limited to one service per day up to a maximum benefit of 90 daily services per Insured per Plan Year.

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

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

Z. 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.

AA. Prenatal and postnatal care, including required visits to the doctor's office and Medically Necessary laboratory tests related to a covered Pregnancy.

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

CC. One contact lens per eye following cataract surgery.

DD. 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.

EE. Home Health Care and Private Duty Nursing 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.

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) Home Health 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.

Nursing care services which are provided in the Insured's home may be provided by any of the following: a Registered Nurse (R.N.); a Licensed Practical Nurse (L.P.N.) or a licensed vocational nurse; as well as services provided in the Insured's home by a Licensed Social Worker.

Coverage also includes Private Duty Nursing services provided by a state licensed nursing agency or state licensed nurse for Medically Necessary services provided on an hourly basis to a homebound Insured.

Covered services that do not require that the patient be homebound are:

(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 (3) home care education visits per Plan Year for which home care education is appropriate.
(2) Home infusion and related services. These services can be provided by either a Medicare certified Home Health Agency, state licensed nursing agency or state licensed nurse.

Home Health Care services do not include:

(1) Services provided by a member of the Insured's immediate family.
(2) Services provided by a person who normally lives in the Insured's home.
(3) Custodial/Maintenance Care. The Company has the right to determine which services are Custodial/Maintenance Care.

FF. 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 payable 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.

GG. Benefits for 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.

HH. Treatment for Mental Illness or Substance Abuse for Inpatient and Outpatient services that are Medically Necessary. Benefits will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Abuse.

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

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

KK. 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

LL. Human Organ & Bone Marrow Transplant Benefits are provided for the following human organ transplants:
1. Cornea
2. Heart
3. Heart-lung
4. Kidney
5. Kidney-liver
6. Liver
7. Lung (whole or lobar, single or double)
8. Multivisceral transplants
9. Pancreas
10. Pancreas-kidney
11. Small intestine
12. Bone marrow and/or peripheral stem cell transplant (High-Dose Chemotherapy with Hematopoietic Support benefits)

Coverage is not provided for any transplant 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.

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.

MM. 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.

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.

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.

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.

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)

NN. Hemodialysis.

OO. Second surgical opinions.

PP. Birthing Center.

QQ. 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.

RR. 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.

SS. 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.

TT. 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.

UU. Prescribed syringes, needles, and colostomy bags.

VV. Surgical and Non-Surgical services of a reversible nature to treat Temporomandibular Joint (TMJ) and Comparable 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.

WW. 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) Equipment used exclusively with diabetes management.

2) Diabetic supplies means syringes, needles, lancets, test strips and solutions, calibration strips, solutions and insulin pump supplies used exclusively with diabetic management.

3) Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and

noninsulin-using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

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

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

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

AAA. Maternity classes conducted by In-Network Providers.

BBB. Evaluation and Treatment of chronic and/or acute pain as specified in our medical policies.

CCC. 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.

DDD. Pulmonary rehabilitation.

EEE. Biofeedback for Treatment of medical diagnoses for urinary incontinence in adults 18 years old and older.

FFF. Spinal Manipulative Services.

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

HHH. 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.

III. 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.

JJJ. Inpatient Rehabilitation Services provided by an Inpatient Rehabilitation Facility.

KKK. Habilitation Services are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Habilitative Service are those services that are:

- designed to assist an Insured to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame;
- are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time; and
- are individualized and there is documentation outlining quantifiable, measurable and attainable Treatment goals.

LLL. Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to: (1) Surgical procedures of the jaw and gums; (2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (3) Removal of exostoses (bony growths) of the jaw and hard palate; (4) Treatment of fractures and dislocations of the jaw and facial bones; (5) Surgical removal of impacted teeth. (6) Treatment (including replacement) for damage to or loss of Sound Natural Teeth caused by an Accidental Injury. (7) Intra-oral dental imaging services in connection with covered oral surgery if such oral surgery occurs within 30 days of the imaging service(s.) (8) General anesthesia (9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury. (10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).

MMM. 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.

NNN. 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.

OOO. 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.

PPP. 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;
9. Counseling to prevent obesity in women aged 40 to 60 years with normal or overweight body mass index.

QQQ. Blepharoplasty of upper lid.

RRR. Medically Necessary Breast reduction. Refer to Utilization Management for prior authorization requirements.

SSS. Surgical Treatment of male gynecomastia.

TTT. 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.

UUU. Diagnosis and Treatment for the cause of infertility which may include office visits, laboratory tests, and radiological studies to diagnose the cause of infertility. Benefits are also provided for the necessary Treatment of the condition unless the Treatment is identified as non-covered (see General Exclusions section). For example, corrective surgical procedures, therapeutic injections, and drug therapy regimens (Pregnyl, Clomid, Clomiphene, Ovidrel, Gonal, Follistim and Cetrotide) are all covered services when medically necessary. Benefits are also available for tests, such as ultrasound, performed to monitor the effectiveness of the fertility drug therapy. Also for any necessary pregnancy testing performed as an integral part of the overall infertility Treatment program.

VVV. Sleep Apnea Treatments including oral pharynx procedures. Refer to Utilization Management for prior authorization requirements.

WWW. Pediatric vision benefits for children under age 19:
a) Routine eye exams as needed when provided by ophthalmologists and optometrists;
b) 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;

c) 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.

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

YYY. 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.

ZZZ. Services related to diagnosis, Treatment and management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is Medically Necessary.

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 [800 Tower Drive, Suite 300 Troy, MI 48098]
Telephone:	[833-600-1311]
Website:	[www.ascensionpersonalizedcare.com]

Covered Prescription Drugs
The Company covers only drugs that are:

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

B. 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.
(11) 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.
(12) Off-label drugs for the Treatment of cancer.

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. three (3) ounces net weight of ointment or cream;
C. a 14-day supply of antibiotics;
D. certain drugs designated by the Company for chronic conditions may be dispensed in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy. Certain limitations may apply including prior authorization, step therapy and quantity limits;
E. 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
[800 Tower Drive, Suite 300
Troy, MI 48098]
Telephone: [833-600-1311]
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 AND PRIOR AUTHORIZATION REQUIREMENTS

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

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:

Company:	Seton Health Plan, dba: Dell Children's Health Plan
Address:	[1345 Philomena St., Suite #305] [Austin, TX 78723]
Phone:	[1-844-995-1145 (TTY: 586-693-1214)]
Fax:	[512-380-7507]
Email:	[SHP-Authorization@ascension.org]

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 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

This list of services requiring Prior Authorization Review 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 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.

c. Services by an immediate family or person who normally lives in the Insured's home. "Immediate family" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service.

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.

55. Adult eye examinations to determine the need for vision correction.

SECTION 7. GRIEVANCE AND APPEALS

This section outlines the procedures for and the time periods applicable to grievances and appeals. The Insured, the Insured's authorized representative, or Physician or health care provider has the right to file a Grievance, file an appeal, and have an External review. It is the policy of this Company to provide Insureds with a full and fair review of grievance and appeal decisions.

Contact Member Services
A Grievance can be provided to us verbally or in writing in any form, by the Insured or on behalf of the Insured. Contact our Member Services team at [833-600-1311, TTY: 586-693-1214] or by email to [apcsupport@ascension.org] if there is a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage. Written complaints or Grievances can also be mailed to us at US Health and Life Insurance Company, [PO Box 1707, Troy, MI 48099-1707].

We will send an acknowledgement letter upon our receipt of your grievance.

An appeal is a request to reconsider a decision about your benefits where either a service or claim has been denied. This includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of healthcare service or benefits, including the admission to, or continued stay in, a healthcare facility. Failure to approve or deny a prior authorization request in a timely manner may be considered as a denial and subject to the appeal process. Rescissions and certain determinations that involve whether we complied with the surprise billing requirements and cost-protections of the No Surprises Act.

To file an appeal, you can mail or email your request to us at:

US Health and Life Insurance Company
[PO Box 1707
Troy, MI 48099-1707
apcsupport@ascension.org]

Definitions
For the purposes of this section, the following terms and their definitions apply:

Grievance: A written appeal of an adverse determination or final adverse determination submitted by or on behalf of an Insured regarding: availability, delivery or quality of health care services regarding an adverse determination; claims payment, handling or reimbursement for health care services; matters pertaining to the contractual relationship between the Insured and the Company; or matters pertaining to the contractual relationship between the Insured, us and the Physician or health care provider.

Adverse Determination: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; and any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.).

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.

Independent Review Organization: An independent review organization (IRO) acts as a third-party medical review resource which provides objective, unbiased medical determinations that support effective

decision making, based only on medical evidence. IROs deliver conflict-free decisions that help clinical and claims management professionals better allocate healthcare resources.

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.

Adverse Determination Appeal Process

Process of Appeals of Prospective, Concurrent and Retrospective Adverse Determinations

If you disagree with our decision, you, your representative or provider may submit an appeal either verbally, in writing, or in person at the Plan's physical location. Verbal filings will be treated as appeals to establish the earliest filing date. If the appeal is made orally, you or your representative are informed of the importance of returning the Appeal Form and any additional information you would like to submit to be considered in the review before a decision on their appeal is made.

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

There are three types of appeals:

- Standard Appeal/Post Service: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- Expedited Appeal: An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees. An expedited appeal is also available for denials of Prescription Drugs and intravenous infusions for which the enrollee is currently receiving benefits. An expedited appeal is also available for a denied step therapy protocol exception request.
- Specialty Appeal: This appeal is available only after we decide the initial appeal. Your health care provider can request a particular type of specialty provider review the case, the appeal or the decision denying the appeal must be reviewed by a health care provider in the Same or Similar Specialty that typically manages the medical, dental, or specialty condition, procedure, or Treatment under discussion for review. Your provider must request the appeal no later than 10 working days after the date the appeal is denied. We will complete the review within 15 working days of receipt of the request.

We will provide a letter of acknowledgement of the appeal within five (5) working days from our receipt of the appeal. This letter will include: acknowledgement of the date we received the appeal; a list of relevant documents needed to be submitted to us; and an appeal form to be completed if the appeal was received by us orally for review of the appeal.

The Adverse Determination Appeal Process includes the following:

1. Appeal decisions are made by a clinical associate or 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 we do not have a Medical Director that is a Same or Similar Specialty, the case is referred to a contracted Same or Similar Specialist. We 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

3. 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.

4. The Physician or provider reviewing the appeal may interview the Insured or the Insured's designated representative.

5. Provide an opportunity for the Insured and his or her representative to examine the Insured'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.

6. 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, we will offer the provider of record a reasonable opportunity to discuss the plan of Treatment for the Insured with our Medical Director. The discussion at a minimum includes the clinical basis for the decision.

Expedited Appeal Process

The 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.

An expedited appeal is reviewed by a health care provider who has not previously reviewed the case and who is of the Same or Similar Specialty as typically manages the medical condition, procedure, or Treatment under review.

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. You will receive 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 we will issue a letter to the Insured, the Insured's authorized representative, or the Insured'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

Standard/Post Service: 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 we received the written appeal or the one-page appeal form.

Expedited Appeals: An expedited appeal determination may be provided to the appealing party by telephone or electronic transmission and shall be followed with a letter within three (3) working days of the initial telephonic or electronic notification.

In a circumstance involving an Insured's Life Threatening condition, denials of Prescription Drugs and intravenous infusions that are currently being received, or if our internal appeal process timelines are not met, the Insured is entitled to an immediate appeal to an external review and is not required to comply with procedures for an internal review of the Adverse Determination.

Timeline for Resolution
Preservice Urgent: No later than 1 working day from the date all necessary information has been received
Preservice (non-urgent): 15 days
Post-Service: 30 days

External Review of Adverse Determination Process

If you disagree with our decision about your appeal and the decision involved medical judgment, then you have the right to ask for an external review by an independent third party. You, a person acting on your behalf, an attorney, or your provider can ask for an external review within 4 months of getting the appeal decision. If you file an appeal or ask for an external review, we will not hold it against you, or your provider.

How to request an external review
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.

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.

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.

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.

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 exhausting the Appeal of an Adverse Decision, whether or not an external review was pursued. However, in the case of an Adverse Decision eligible for external review involving a Life Threatening 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.

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.

Conformity with Applicable Law
Any provision of the Policy which, on its Effective Date, is in conflict with an applicable federal or state 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 Illness 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:

[Cigna Pharmacy Service Center
PO Box 188053
Chattanooga, TN 37422-8053]

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 Worker's 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.