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 canceled by Us except for specified situations described in this contract.

PREMIUMS ARE SUBJECT TO CHANGE AT POLICY RENEWAL. Renewal premiums for this policy will increase periodically depending upon your age and policy year. We will provide a 60 day advance written notice prior to the date the rate change will take effect.

Each premium is to be paid to us on or before its due date. The initial premium must be paid prior to the coverage effective date, although an extension may be provided during the annual Open Enrollment period.

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 healthcare 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]

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

US Health and Life Insurance Company (USHL)
To get information or file a complaint with your insurance company:

Call: Member Services
Toll-free: [1-833-600-1311]
Online: [ascensionpersonalized.com]
Email: [apcsupport@ascension.org]
Mail: [PO Box 1707, Troy, MI 48099-1707]

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: [1-800-252-3439]
File a complaint: [www.tdi.texas.gov]
Email: [ConsumerProtection@tdi.texas.gov]
Mail: [MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091]

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presenter una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

US Health and Life Insurance Company (USHL)
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Member Services
Teléfono gratuito: [1-833-600-1311]
En línea: [ascensionpersonalized.com]
Correo electrónico: [apcsupport@ascension.org]
Dirección postal: [PO Box 1707, Troy, MI 48099-1707]

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: [1-800-252-3439]
Presente una queja en: [www.tdi.texas.gov]
Correo electrónico: [ConsumerProtection@tdi.texas.gov]
Dirección postal: [MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091]

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 Plan allows USHL the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. USHL, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- USHL anticipates future expenditures for Eligible 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 a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination (except for terminations due to failure to meet applicable quality standards or for fraud), USHL will continue providing coverage for that Provider's services at the In-Network benefit level if the Insured (a) is undergoing a course of treatment for a "serious and complex condition" from the Provider or facility; (b) is undergoing a course of institutional or inpatient care from the Provider or facility; (c) is scheduled to undergo non-elective surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a surgery; (d) is pregnant and undergoing a course of Treatment for the pregnancy from the Provider or facility; or (e) is or was determined to be terminally ill and is receiving treatment for such Illness form such provider or facility.

A "serious and complex condition" is (i) in the case of an acute Illness, a condition that is serious enough to require specialized medical Treatment to avoid the reasonable possibility of death or permanent harm; or (ii) in the case of a chronic Illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

If the Network Provider is terminated due to failure to meet applicable quality standards or for fraud, 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.

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 who are pregnant at the time the Provider's termination takes effect, continuity of care 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.

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SECTION 1. GENERAL DEFINITIONS

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

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

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

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

"Ambulatory Care Center" means a specialized facility:

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

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

1) it is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing Surgical Procedures; and
2) it is operated under the supervision of a licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Acute Care Hospital in the area; and
3) it requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the Surgical Procedure; and
4) it provides at least 2 operating rooms and at least one post-anesthesia recovery room; to be equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply; and
5) it provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room; and
6) it maintains a written agreement with at least one Acute Care Hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement; and
7) it maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report, and a discharge summary.

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

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

1. The National Institutes of Health.
2. The Centers for Disease Control and Prevention.
3. The Agency for Health Care Research and Quality.
4. The Centers for Medicare & Medicaid Services.
5. Cooperative group or center of any of the entities described in clauses (1) through (4) or the Department of Defense or the Department of Veterans Affairs.
6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7. Any of the following if the conditions described in paragraph (2) are met:
   a. The Department of Veterans Affairs.
   b. The Department of Defense.
   c. The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

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

Conditions for departments:

The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines—

(A)to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B)assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

"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 a usual 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.

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

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

> “Individual Deductible” shall mean the amount of Covered Expenses that an Individual must satisfy within a Plan Year, before eligible for certain benefits to be payable by the Company.
>
> “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 grandchild of the Insured regardless of whether the child is claimed as an exemption for federal income tax purposes.
- A legally adopted child.
- A child placed for adoption including when the Insured is a party to a suit in which they seek to adopt the child.
- 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 60 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 a health condition that is manifested by acute symptoms of sufficient severity including severe pain, 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. serious disfigurement; or

E. 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 delivered by Physicians or health-care providers at the usual and customary or agreed rate, regardless of whether Physicians or providers are In-Network or Out-of-Network Providers. Covered services include:

- Medical screening examination or other evaluations required by Texas or federal law to be provided in hospital emergency facilities that are necessary to determine whether medical emergency conditions exist;
- Necessary Emergency Services, including treatment and stabilization of Emergency Medical Conditions; and
- Services originating in hospital emergency or comparable facilities following treatment or stabilization of emergency medical conditions.

"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.

Routine Patient Care Costs do not include:
1. the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. a cost associated with managing a clinical trial; or
5. the cost of a health care service that is specifically excluded from coverage under this Policy.

“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.

“Home Health Agency” means a business that: (a) provides home health services; and is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

"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 (ICD-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.

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

"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;
- Chemical Dependency Counselors;
- 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);
- Nurse first assistants;
- Surgical assistants;
- Psychologist and Psychological associates;
- Psychiatrist licensed in the state in which the psychiatrist practices;
- Speech-Language Pathologist; and
- Pharmacists.

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 canceled 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-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Complications also include 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 covered 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 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 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 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).

“Related Confinement" means any confinement unless:

A. the subsequent confinement is due to causes entirely unrelated to the causes of the previous confinement; or
B. the confinements are separated by a continuous period of at least 2 weeks;

“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.

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

“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 Pharmacopeia-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 danger. “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 for a physician’s office, that provides treatment or services that are required:

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

<u>Effective Dates for All Other Special Enrollment Events</u>

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
<u>Triggering Events Effective on the First of the Month Following the Event</u>

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 31days 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

1. Coverage under the contract may be canceled 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 the product offered through this Policy.
      i. 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 individual market in the State of Texas,
      i. In this event We will provide notice to You and to the State of Texas 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. Dependents who no longer qualify under the general definition of Insured.

For individuals receiving advance premium tax credits, we will continue to pay all appropriate claims for covered services rendered to the enrollee during the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the enrollee, as well as providers of the possibility of denied claims when the enrollee is in the third month of the grace period. We will continue to collect advanced premium tax credits on behalf of the enrollee from the Department of the Treasury, and will return the advanced premium tax credits on behalf of the enrollee for the second and third month of the grace period if the enrollee exhausts their grace period as described above. An enrollee is not eligible to re-enroll once terminated, unless an enrollee has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

Continuation of Coverage Due to Divorce or Death

If a Dependent spouse loses coverage due to divorce, we will issue that spouse a policy that we are issuing at the time that most nearly approximates the coverage of the policy which was in effect prior to the divorce. This policy will be issued without evidence of insurability and will be effective on the date issued and expire on the same date as the policy under which coverage was issued prior to the divorce.

In the event of the Policyholder's death, the spouse of the Policyholder, if covered under the Policy, will become the Policyholder.

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, 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.

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

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

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 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.

Medically Necessary covered services will be paid when provided by an Out-of-Network provider who is a facility-based provider at the Qualifying Paying Amount as defined by Section 102 of the federal No Surprises Act if the provider performed the service at a healthcare facility that is In-Network.

We will provide coverage for an Out-of-Network diagnostic imaging provider and laboratory service provider who provides services in connection with Emergency Services when the medical services are performed by an In-Network provider. These providers will be paid at the Qualifying Paying Amount as defined by Section 102 of the federal No Surprises Act.

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. While the Insured is an Inpatient in an Acute Care Hospital, Intensive Care Unit accommodations will be furnished. If the Insured occupies a private room, only the average Semi-Private Room and Board rate is covered.

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 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, speech, and respiratory therapy provided in the Insured's home by licensed therapists.
   c. Use of medical equipment.
4. Respite care.
5. Prescription drugs.
6. Bereavement services

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

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

F. 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 .

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 Maximum Allowed Amount 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 services received for urgent care, including facility charges 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. This coverage is limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the Insured as determined by the Insured's treating Physician or podiatrist and prosthetist or orthotist, as applicable.

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. This coverage is limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical

needs of the Insured as determined by the Insured's treating Physician or podiatrist and prosthetist or orthotist, as applicable.

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, electroencephalograms, laboratory testing and pathological examinations when performed by a Physician for the diagnosis of an Illness or Injury. We will pay for medical care or health care service performed by or a covered supply related to that service provided to an insured by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the In-Network cost sharor at an agreed rate if the provider performed the service in connection with a medical care or health care service performed by a preferred provider.

U. 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. Visit limitations for these Outpatient services are set out in the Schedule of Benefits. The visit limitations do not apply to Medically Necessary services for acquired brain injury, autism spectrum disorder, and development delays.

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

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.

X. Dental services needed to correct damage to a Sound Natural Tooth caused by accidental Injury when treatment begins within 30 days of the accident. Dental services needed to correct damage caused solely by external, violent accidental Injury to Sound Natural Teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an accidental Injury.

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

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

AA. 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.

BB. Pre-natal and postnatal care, including required visits to the doctor's office and Medically Necessary laboratory tests related to a covered Pregnancy.

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

DD. One contact lens per eye following cataract surgery.

EE. 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.

FF. All Home Health Care services including home infusion and related services, require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records to review to determine whether services are eligible under this contract.

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.

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 home care education visits per Plan Year for which home care education is appropriate.
(2) Home infusion and related services.

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.

GG. Skilled Nursing Facility expenses if:

1. The Insured was first an Inpatient in an Acute Care Hospital ;
2. A Physician orders Skilled Nursing Facility confinement for convalescence from a condition which caused that Acute Care Hospital stay or related conditions; and
3. The Insured is under a Physician's continuous supervision and requires 24-hour nursing care.

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.

HH. 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.

II. 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.

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

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

LL. 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

MM. Human Organ & Tissue Transplant Benefits are provided for the human organs and FDA approved artificial devices in accordance with the following:

a. Subject to the conditions described below, benefits for covered services and supplies provided to the Insured person by a hospital, Physician, or other provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

1. The transplant procedure is not Experimental/Investigational in nature; and
2. Donated human organs or tissue or an FDA-approved artificial device are used; and
3. The recipient is an Insured person under this Policy; and
4. The transplant procedure is preauthorized as required under the Policy; and
5. The Insured person meets all of the protocols established by the hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:
1. A recipient who is covered under this Policy; and
2. A donor who is an Insured person under this Policy; or
3. A donor who is not an Insured person under this Policy.

c. Covered services and supplies include services and supplies provided for the:
1. Donor search and acceptability testing of potential live donors; and
2. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
3. Removal of organs or tissues from living or deceased donors; and
4. Transportation and short-term storage of donated organs or tissues.

d. No benefits are available for an Insured person for the following services or supplies:
1. Living and/or travel expenses of the recipient or a live donor;
2. Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
3. Purchase of the organ or tissue; or
4. Organs or tissue (xenograft) obtained from another species.

e. Prior approval is required for any organ or tissue transplant (other than Corneal Transplants).
1. Such specific preauthorization is required even if the patient is already a patient in a hospital under another preauthorization authorization.
2. At the time of preauthorization, USHL will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if USHL determines that an extension is Medically Necessary.

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which USHL considers to be Experimental/Investigational.

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

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

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

-- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or
-- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved.

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

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)

Medically recognized screening examination for the detection of colorectal cancer for persons aged 45 or older and at normal risk for developing colon cancer which includes the following:

- all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of “A” or “B” in the future, and
- an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

OO. Hemodialysis.

PP. Second surgical opinions.

QQ. Birthing Center.

RR. 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.

SS. 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.

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

1. 2-view, low dose radiation mammography;
2. Diagnostic imaging - For purposes of this benefit means, an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate the following:
   (a) a subjective or objective abnormality detected by a physician or patient in a breast;
   (b) an abnormality seen by a physician on a screening mammogram;
   (c) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
   (d) an individual with a personal history of breast cancer or dense breast tissue.
3. surgical breast biopsy and pathologic examination and interpretation;

Limited to (1) one screening per Plan Year for each insured 35 and over. The age limitation does NOT apply to Diagnostic imaging.

UU. 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.

VV. Prescribed syringes, needles, and colostomy bags.

WW. 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.

XX. 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.

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

a) Blood glucose monitors including noninvasive glucose monitors and and blood glucose monitors for the legally blind.
b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and lancet devices.
c) Insulin and insulin analogs.
d) Injection aids.
e) Syringes.
f) Insulin pumps and medical supplies required for the use of an insulin pump.

g) Insulin infusion devices.
h) Podiatric appliances for the prevention of complications associated with diabetes.
i) Prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and
j) glucagon emergency kits.
k) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition, subject to the following:
    i. Is limited to completion of a certified diabetes education program upon occurrence of either of the following:
        1. If considered Medically Necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
        2. If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.
    ii. Shall be provided by a diabetes Outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

The term “diabetes” includes all of the following:

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

YY. Allergy testing, evaluations and injections, including serum costs. Medically Necessary allergy testing on an Outpatient basis.

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

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

BBB. Maternity classes conducted by In-Network Providers.

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

DDD. 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 .

EEE. Pulmonary rehabilitation.

FFF. Biofeedback for treatment of medical diagnoses for urinary incontinence in adults 18 years old and older.

GGG. Chiropractic treatment.

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

III. 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.

JJJ. 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.

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

LLL. 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.

Occupational therapy does not include physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

Visit limitations are set out in the Schedule of Benefits. The visit limitations do not apply to Medically Necessary services for acquired brain injury, autism spectrum disorder, and development delays.

MMM. Covered oral surgical (Medical) services within an office setting may include:

- Surgical procedures of the jaw and gums.
- Removal of tumors and cysts of the jaws, cheeks, lips, tongue roof and floor of the mouth.
- Surgical removal of impacted teeth, benign or malignant lesions (not including inflammatory lesions).
- Medical services, such as suturing of lacerations required in connection with covered oral surgery due to oral surgical services to Sound Natural Teeth.

NNN. 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.

OOO. 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.

PPP. 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.

QQQ. 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. Cervical cancer (PAP) screenings which includes a CA 125 blood test and any other test or screening approved by the USFDA for the detection of ovarian cancer.

RRR. Blepharoplasty of upper lid.

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

TTT. Surgical treatment of male gynecomastia.

UUU. 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.

VVV. Pediatric vision services and supplies for children under age 19 which includes:

- Routine exam once every Plan Year.
- One pair of lenses or Medically Necessary contact lenses in lieu of eyeglass lenses once every Plan Year.
- Frames covered once every Plan Year.

The following services are not covered:
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Policy which are lost, stolen, or damaged, except at the normal intervals when Policy benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

Additional State Mandated Coverages:

1. Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

   Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

   Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

   Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

   To ensure that appropriate post-acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:
   1. has incurred an Acquired Brain Injury;
   2. has been unresponsive to treatment; and
   3. becomes responsive to treatment at a later date.

   Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

2. Coverage of certain rehabilitative or habilitative therapies for children who have developmental delays, including:
   - Dietary or nutritional evaluations and services;
   - Occupational therapy evaluations and services;
   - Physical therapy evaluations and services, and;

- Speech therapy evaluations and services.

3. Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis.

4. Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:
   a. A physical examination for the detection of prostate cancer; and
   b. A prostate-specific antigen test for each covered male who is:
      (1) At least 50 years of age; or
      (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

5. Screening benefits are covered up to $200 every five (5) years, performed by a laboratory that is certified by a national organization recognized by the commissioner for men aged 46-75 and women aged 56-75 who are diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:
   1. Computed tomography (CT) scanning measuring coronary artery calcification; or
   2. Ultrasonography measuring carotid intima-media thickness and plaque.

6. Newborn screening tests required by Section 33.011, Health and Safety code, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services on its Internet website under Section 33.019 of that code on the date the test was administered.

7. Screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety code and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

8. Immunizations for children from birth through age 6:
   - Diptheria;
   - Haemophilus influenza type b;
   - Hepatitis B;
   - Measles;
   - Mumps;
   - Pertussis;
   - Polio;
   - Rubella;
   - Tetanus;
   - Varicella; and
   - Any other immunization required by law.

9. Medically Necessary foot orthotics are covered subject to the same Deductibles, Coinsurance, and Copayments as for services and supplies generally. There is no Plan Year maximum. This is in addition to the coverage for orthotics prescribed for a person with diabetes.

10. Medically necessary hearing aid or cochlear implant and related services and supplies for Insured's . This includes the following:

    (A) fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

    (B) any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and

(C) for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

Limited to the following:

(A) one hearing aid in each ear every three years; and

(B) one cochlear implant in each ear with internal replacement as medically or audiologically 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. Modifications will occur at the time of the plan renewal and coverage for the drug being removed will continue to be covered until the renewal date of the plan. 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 are 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.

The Step Therapy process does not apply to coverage for stage-four advanced, metastatic cancer and associated conditions. No proof of history of failure or failure to respond to a different drug will be required. This applies when the drug prescribed is consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the USFDA.

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

C. 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 if applicable.
(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) Medically necessary new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the FDA. (The cost share for a 30-day supply of insulin will never exceed $25 per prescription.)
(10) Emergency refills of insulin and insulin-related equipment. (Emergency refills of diabetes equipment or diabetes supplies without prescribing practitioner authorization, must be covered in the same manner as a nonemergency refill.)
(11) Prenatal Vitamins for females between the ages of 10 and 65 years old;
(12) Over-the-counter preventive care medication if prescribed by a Physician.
(13) 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.
(14) Amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:
   - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
   - Severe food protein-induces enterocolitis syndromes;
   - Eosinophilic disorders, as evidenced by the results of biopsy; and
   - Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

   A prescription order from your Physician is required.
(15) Accelerated refills for eye drops when they are needed and the refill does not exceed the dosage originally prescribed by the provider. A refill will not be prescribed earlier than: the 21st day after the date a 30 day supply was dispensed; the 42nd day after the date a 60 day supply was dispensed; and the 63rd day after the date a 90 day supply was dispense.

Insured's will not be required to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of the applicable copayment; the allowable claim amount of the prescription drug; or the amount an Insured would pay for the drug if the Insured purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

Benefits for prescription drugs shall prorate any cost-sharing amount charged for a partial supply of a prescription drug if the pharmacy or the Insured's prescribing Physician or health care provider notifies us and the Insured agrees that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the Insured's prescription drugs and it is in the Insured's best interest. Prorated prescription drugs are based on the number of days' supply of the drug actually dispensed.

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 Insured's satisfy the Prior Authorization requirements.

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

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

A. one (1) vial of insulin;
B. eight (8) fluid ounces of liquid medication;
C. three (3) ounces net weight of ointment or cream;
D. a 14-day supply of antibiotics;
E. 90 days supply for Home Delivery (if the Home Delivery Option is selected);
F. a sufficient supply to provide appropriate continuing medication during an Insured’s quote temporary absence from an area where a Participating Pharmacy is available, subject to prior review and approval by US Health and Life Insurance Company.

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

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

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

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

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

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

Address: US Health and Life Insurance Company
Attention: Customer Service
[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 unless specifically listed as a Covered Medical Expense.
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 unless specifically listed as a Covered Medical Expense.
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 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 these Prescription Drug exclusions.
32. Vaccines and Immunizations except for immunizations as covered in the Medical Benefits section in this Policy.

SECTION 5. UTILIZATION 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 Investigational 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. However, if the covered service was found to be Medically Necessary, we will pay up to 50% of the allowable charge.

Prior Authorization Renewal process
We will permit a Physician or healthcare provider to request a renewal at least 60 days before the existing prior authorization expires and if practicable, review the request and issue a determination indicating whether the medical or health care service is prior authorized before the existing prior authorization expires.

SECTION 6. GENERAL EXCLUSIONS

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

1. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished before the effective date of coverage of the Insured on whose account the charge is made or which was furnished in connection with or during a Confinement which commenced before that date; or
2. for which a claim for benefits is made more than one year after the expense is incurred; or
3. for services incurred after eligibility is terminated; or
4. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished without the recommendation and approval of a Physician or Dentist acting within the scope of his license; or
5. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service, supply, or drug that is not Medically Necessary to the care and treatment of any Injury or Illness of the Insured on whose account the charge is made, unless such procedure is specifically listed as eligible under Covered Medical Expenses; or
6. for services rendered for treatment of an Injury or Illness for which benefits are available under Workers' Compensation or Employer liability law, or services rendered for any Injury or Illness sustained as a result of any work for wage or profit; or
7. for services rendered in connection with an Injury or Illness that is not a Non-occupational Injury or Illness; or
8. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply furnished by or through any government or any subdivision or agency of a government, or the charge for which is paid or payable or reimbursable by or through any policy or program of any government or any subdivision or agency of a government, other than a policy, plan or program of a government or of a subdivision or agency of a government unless payment is legally required; or
9. which would not have been made in the absence of coverage or professional courtesy service, or which the Insured is not legally obligated to pay or to the extent that the Company is prohibited from providing benefits for such charge, by any law or regulation; or
10. for Out-of-Network charges in excess of what is generally considered to be usual or customary; or
11. for which any loss to which a contributing cause was the Insured’s commission of or attempt to commit a felony or to which a contributing cause was the Insured’s being engaged in an illegal occupation or other willful criminal activity. Willful criminal activity includes, but is not limited to, operating a vehicle while intoxicated in violation of any applicable law. Willful criminal activity does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.
12. made for or in connection with any Confinement, or any examination, or any surgical, medical or other treatment, or any service or supply for which benefits are furnished, paid for, or required by reason of service in the armed services of any country; or
13. for treatment or services that were received outside of the United States, its protectorates, Canada or Mexico, except if the treatment is for a Medical Emergency; or
14. for care, treatment, services, and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care; or

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

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

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

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

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

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

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

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

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

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

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

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

27. for breast implants for solely cosmetic reasons; or

28. for sterilization reversal; or

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

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

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

32. for services for or related to elective abortions. “Elective abortion” means an abortion, as defined by Section 245.002, Health and Safety Code, other than an abortion performed due to a medical emergency as defined by Section 171.002, Health and Safety Code.

33. for paternity testing; or

34. for home uterine activity monitoring devices; or

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

    a. as a result of a covered accidental Injury or Illness; or
    b. repair as a result of congenital abnormalities and hereditary complications or conditions; or

c. for reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance; or
d. for reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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

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

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

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

39. for treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, except for treatment of injury to Sound Natural Teeth due to an accident; or

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

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

42. for laser or radial keratotomies; or

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

44. for hair replacement or removal; or

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

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

47. for marriage counseling; or

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

49. any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Insured has other health conditions which might be helped by a reduction of obesity or weight; or

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

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

52. for bio-feedback training; or

53. for music therapy or reading therapy; or

54. for hypnotherapy; or

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

56. for educational training or testing; or

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

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

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

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

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

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

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

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

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

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

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

68. Charges made by an Assisted Living Facility.

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 four 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 unless the following apply;
    - We waive an internal appeal;
    - Urgent care situations (expedited external review may be initiated at the same time as expedited internal appeals); and
    - Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
        - De minimis;
        - Non-prejudicial;
        - Attributable to good cause or matters beyond the our control;
        - In the context of an ongoing good faith exchange of information; and
        - Not reflective of a pattern or practice of non-compliance.

  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.

- Acquired Brain Injury Appeal: An appeal concerning an acquired brain injury.

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.

3. 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, your provider will be offered a reasonable opportunity to discuss the plan of treatment for your care with the physician reviewing your case. The discussion at a minimum includes the clinical basis for the decision.

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

4. 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.

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

6. 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.

7. 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 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 72 hours from the date all necessary information has been received
Preservice (non-urgent): 15 days
Post-Service: 30 days

<u>External Review of Adverse Determination Process</u>

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
Maximus Federal Services, Inc. is the independent review organization that will conduct the external review. You can use forms from Maximus to ask for an external review or send a written request, including any additional information for review. You can get the Maximus forms by calling Member Services, Maximus at 1-888-866-6205 ext. 3326 or online at https://externalappeal.cms.gov.

Fill out one or both of the Maximus forms based on who will ask for the external review. Complete:

- The HHS-Administered Federal External Review Request Form to request an external review yourself.
- Both the HHS-Administered Federal External Review Request Form and the Appointment of Representative Form if you want your child's provider or another person to ask for the external review for you.
    - Both you and your authorized representative need to complete this form.

Or, send a written request with:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Signature of member, parent or legal guardian, or authorized representative
- A short description of the reason you disagree with our decision

Send your forms or written request to 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]

You can also send your request directly to Maximus by one of the ways below:

Online:
https://externalappeal.cms.gov. - Use "Request a Review Online" tab

Mail:
HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534

Fax: 1-888-866-6190

If you send additional information to Maximus for the review, it will be shared with Seton Health Plan dba: Dell Children's Health Plan so that we can reconsider the denial. If you have questions during the external review process, contact Maximus at [1-888-866-6205, ext. 3326] or go to https://externalappeal.cms.gov

You can ask for an expedited external review:

- If you asked for an expedited appeal after our initial denial and waiting up to 72 hours would seriously jeopardize your child's life, health or ability to regain maximum function, you can request an expedited external review at the same time
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize your child's life, health or ability to regain maximum function

- If the appeal decision is about an admission, availability of care, continued stay, or health-care service for which emergency services were received but the member has not been discharged from the facility

How to request an expedited external review:
- online: you can select "expedited" when submitting the review request; or
- email: [FERP@maximus.com]; or
- call: Federal External Review Process at [1-888-866-6205 ext. 3326]

We will accept the external reviewer's decision related to the medical necessity, appropriateness or experimental or investigational nature of health care services for you. We will be responsible for paying any charges for the external review.

If you, your authorized representative, or provider has any questions regarding the appeal process, please contact us at [1-844-995-1145 (TTY: 586-693-1214)].

Or you may contact the Texas Department of Insurance (TDI) on the IRO information line at [(888) TDI-2IRO (834-3476, or in Austin call (512) 322-3400] to obtain more information about the IRO process.

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 state's or federal 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
[P.O. 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.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:
• the third party is named in a court order as managing or possessory conservator of the child; and
• USHL has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to USHL, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

USHL may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by USHL from benefit payments of amounts owed to USHL, will be considered in satisfaction of its obligations to you under the Plan.

An Explanation of Benefits summary is sent to you so you will know what has been paid.

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.

State Government Programs
1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Health and Human Services Commission to the extent required by the Texas Insurance Code; and

2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Health and Human Services Commission where;

a. The Texas Health and Human Services Commission is paying benefits pursuant to provisions in the Human Resources Code; and
b. The parent who is covered under the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
c. The Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Health and Human Services Commission .

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 3 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 health 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.

Texas Department of Insurance Notice

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.
- You have the right to an adequate network of preferred providers (known as "network providers").
    - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.
- You may obtain a current directory of preferred providers at the following website: [www.ascensionpersonlizedcare.com] or by calling [833-600-1311, TTY: 586-693-1214] for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by US Health and Life Insurance Company. This notice is required by legislation to be provided to you. If you have questions regarding this notice, call US Health and Life Insurance Company at [833-600-1311, TTY: 586-693-1214] or write to us at Ascension Personalized Care [P.O. Box 1707, Troy,] Michigan [48099-1707].

Minimum Inpatient Stay for Mastectomy or Lymph Node Dissection/Reconstructive Surgery After Mastectomy

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.

The minimum stay for Inpatient care following a mastectomy is 48 hours; and 24 hours following lymph node dissection for the treatment of breast cancer, unless your Physician determines that a shorter period of Inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours. We also may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Coverage for Acquired Brain Injury

The following services when Medically Necessary for an acquired brain Injury:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration service, including outpatient day treatment service or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain Injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain Injury does not result in hospitalization or acute-care treatment does not affect the right of the Insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. A physical examination for the detection of prostate cancer; and
b. A prostate-specific antigen test for each covered male who is:
    i. At least 50 years of age; or
    ii. At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

c. 48 hours following an uncomplicated vaginal delivery; and
d. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.