National Health Insurance Company
[4455 LBJ Freeway
Suite 375
Dallas TX, 75244]

PARTICIPATING PROVIDER MAJOR MEDICAL INSURANCE CERTIFICATE
With Child Dental and Child Vision Benefits

The insurance described in this Certificate is effective on Your Effective Date only if You are eligible for the insurance, become insured, and remain insured subject to the terms, conditions, limitations, and exclusions of this Plan.

This Certificate is evidence of Your coverage under the Group Major Medical Policy of insurance issued to the Policyholder for Your benefit.

This Certificate describes the benefits and major provisions that affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Group Major Medical Policy. The Policy is issued in the state of Missouri and is governed by applicable laws of that state and federal laws, except as otherwise provided by this Certificate or the Policy.

The Policy is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., unless the Policyholder is not an employee welfare benefit plan as defined by ERISA. If You have any questions about this statement or about Your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor.

The Policy may be examined at Our Home Office or the main office of the Policyholder.

This Certificate is issued based on the statements and agreements in the enrollment form, any other amendments or supplements and the payment of the required premium. This Certificate and/or the Policy may be changed.

Please read Your Certificate carefully and become familiar with its terms, conditions, limitations, and exclusions.

You may return the Certificate within at least ten (10) days of delivery for a full refund of all premiums paid. Any coverage returned for a refund of premium will be null and void from its inception.

[signature]
President

[signature]
Secretary

THIS CERTIFICATE CONTAINS A
PRE-AUTHORIZATION AND OTHER UTILIZATION REVIEW PROVISIONS SECTION
Benefits may be reduced if You fail to pre-authorize certain treatments. Read the Pre-Authorization and Other Utilization Review Provisions section carefully.

GUIDE TO YOUR CERTIFICATE

The sections of the Certificate appear in the following order:

PRE-AUTHORIZATION AND OTHER UTILIZATION REVIEW PROVISIONS

Our Medical Review Manager will review proposed and completed medical care to determine the Medical Necessity and appropriateness of treatment. A review by Our Medical Review Manager does not guarantee that benefits will be paid. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of this Plan.

Pre-Authorization
Prior to obtaining services, contact Us for pre-authorization in accordance with the Pre-Authorization Process provision below.

PRE-AUTHORIZATION ADDRESSES ONLY THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE TREATMENT TO BE RECEIVED, INCLUDING THE TYPE OF TREATMENT AND FACILITY, AND DOES NOT GUARANTEE BENEFITS WILL BE PAID.

PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS IN THIS CERTIFICATE.

Pre-Authorization Process
A list of the treatment, services, or supplies that require pre-authorization, and a recommended timeframe in which to contact Us, is shown below in the When to Call provision.

Benefits will be reduced, as described in the Reduction of Payment provision, if a Covered Person does not comply with this Pre-Authorization Process and does not obtain Our authorization.

For medical services that require pre-authorization, contact Our Medical Review Manager by calling the toll-free number located on the ID card. Please have all of the following information on hand before calling:

1. The Certificate number for this Plan.
2. The Health Care Practitioner's name, telephone number, fax number, and URL address, if applicable.
3. The service, procedure, and diagnosis code.
4. The proposed date of admission or date the service or procedure will be performed.
5. The facility's name, telephone number, fax number, and URL address, if applicable.

The Medical Review Manager may review a proposed service or procedure to determine:

1. Medical Necessity;
2. whether it is a Cosmetic Service or an Experimental or Investigational Service;
3. location of the treatment; and,
4. length of stay for an Inpatient confinement.

As part of the review process, the Medical Review Manager may require, at Our expense, a second opinion from a Health Care Practitioner recommended by the Medical Review Manager. A treatment plan may be required as part of the authorization process. We may require that conservative treatments be tried and fail before We authorize coverage of more costly or complex treatments.

When to Call
Contact the Medical Review Manager for pre-authorization of the following services.

1. Inpatient Confinements: Call Us to obtain pre-authorization for an admission to, or transfer between, an Acute Behavioral Health Inpatient Facility, a Hospital, an Acute Medical Rehabilitation Facility, a Behavioral Health Rehabilitation and Residential Facility, a Subacute Rehabilitation Facility, a Hospice facility, a Skilled Nursing Facility or any other Inpatient confinement that will exceed 24 hours as follows:

    a. *Non-Emergency Confinements:* Call at least 7 business days prior to an Inpatient admission for a Non-Emergency Confinement that will exceed 24 hours in duration.
    b. *Emergency Confinements:* Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in duration. The Covered Person must provide, or make available to, the Medical Review Manager the full details of the Emergency Confinement. Covered Emergency Treatment will be provided without the requirement for prior authorization, regardless of whether the provider is a Participating Provider or not.
    c. *Maternity Confinements:* If the Inpatient confinement exceeds 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated caesarean section delivery, the Covered Person must call prior to the end of the confinement, or as soon as reasonably possible. Any other Inpatient confinements that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions.

    Note: That portion of an Inpatient confinement that exceeds the number of days authorized will be considered unauthorized, unless an extension is granted. To request an extension of the authorization, the Health Care Practitioner must contact Us at least 24 hours prior to the originally scheduled discharge date. Our Medical Review Manager may or may not authorize an extension. Refer to the Reduction of Payment provision below to determine how benefits may be reduced if an extension is not obtained from Us.

2. Outpatient Procedures: Call Us to obtain pre-authorization for any of the following services or procedures listed below that are performed on an Outpatient basis in a Hospital, an Acute Medical Rehabilitation Facility, a Free-Standing Facility, a Subacute Rehabilitation Facility, an Urgent Care Facility, or in a Health Care Practitioner's office.
    - Call at least 7 business days prior to receiving any non-emergency Outpatient services that are listed below.
    - Call within 24 hours, or as soon as reasonably possible, after receiving any Emergency Outpatient services listed below.

        a. Any surgical procedures, except those rendered in a Health Care Practitioner's

office.

b. Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
c. Dialysis.
d. Hyperbaric Oxygen Therapy (HBOT).
e. Radiation therapy, including but not limited to:
    i. Brachytherapy (internal radiation therapy);
    ii. Conventional external beam radiation therapy (CRT);
    iii. Image guided radiotherapy (IGRT);
    iv. Intensity-modulated radiotherapy (IMRT);
    v. Ionizing radiation;
    vi. Proton therapy (proton beam therapy) (PBT);
    vii. Stereotactic radiosurgery (SRS); or,
    viii. Three-dimensional conformal radiation therapy (3DCRT).
f. Implants, prosthesis, and/or replacement of any joint, including but not limited to spine, knee, and hip.

3. Transplants: Call Us to obtain pre-authorization at least 7 business days prior to beginning any transplant evaluation, testing, preparative treatment, or donor search.

4. Gene therapy**:** Call Us to obtain pre-authorization at least 7 business days prior to any gene therapy evaluation, testing, preparative treatment, or services.

5. Pharmaceuticals: Call Us to obtain pre-authorization at least 7 business days prior to obtaining any drug regimen for which Our Drug List requires authorization. This may include, but is not limited to: obtaining Specialty Pharmaceuticals or beginning a course of non-intravenous injectable drug therapy or intravenous injectable parenteral drug therapy, such as chemotherapy. Our Drug List identifies which Prescription Drugs require prior authorization. The Drug List website is shown on Your Benefit Summary.

6. Habilitative and Rehabilitative Services, including Physical Medicine, applied behavior analysis for Autism, Adjustments and Manipulations: Call Us to obtain pre-authorization at least 7 business days prior to beginning a course of treatment [if the anticipated course of treatment will exceed 12 visits or will last longer than 30 days].

7. Non-Emergency Professional Transportation: Call Us to obtain pre-authorization at least 7 business days, or as soon as reasonably possible, prior to any non-emergency professional ground, air, or water ambulance transportation, by any means, for a Covered Person who is under the care or supervision of a Health Care Practitioner when the transport is any of the following:

    a. To a Hospital that provides care, services, or treatment that was not available at the original Hospital.
    b. To a more cost-effective Inpatient facility that can provide care, services, or treatment for the Covered Person's Sickness or Injury.
    c. From a facility that provides acute care, to a facility that provides Subacute Medical Care, on an Inpatient basis.
    d. From a facility that provides acute care or Subacute Medical Care on an Inpatient basis, to the Covered Person's home, when professional transportation in an ambulance is determined to be Medically Necessary.

8. Durable Medical Equipment and Personal Medical Equipment: Call Us to obtain pre-authorization at least 7 business days prior to the purchase or rental of Durable Medical Equipment and Personal Medical Equipment with a purchase price in excess of $1,500.

9. Home Health Care and Hospice Care: Call Us to obtain pre-authorization at least 7 business days prior to beginning Home Health Care or Hospice Care.

10. Child Vision Services: Call Us to obtain pre-authorization at least 7 business days prior to receiving a comprehensive low vision evaluation or examination.

11. Child Orthodontic Dental Services: Call Us to obtain pre-authorization at least 7 business days prior to beginning any Orthodontic Treatment.

12. Foot care: Call Us to obtain pre-authorization at least 7 business days prior to obtaining foot care for peripheral vascular disease, peripheral neuropathy, circulatory disorders in the lower extremities, or chronic arterial or venous insufficiency.

Pre-Authorization Review Decisions
For initial review determinations, We will make the determination within 36 hours, which will include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. Necessary information includes the results of any face to face clinical evaluation or second opinion that may be required. In the case of a determination to certify an admission, procedure or service or in the case of an adverse determination, We will notify the provider rendering the service by telephone or electronically within 24 hours of making the initial or adverse determination. We will provide written or electronic confirmation of the telephone or electronic notification to You and the provider within two working days of making the initial determination to certify an admission, procedure or service or within one working day of making the adverse determination.

The Medical Review Manager will review the pre-authorization request, and will determine (in consultation with the Covered Person's Health Care Practitioner) whether a service listed in the When to Call provision is Medically Necessary. The Medical Review Manager will certify all such medical care that is determined to be Medically Necessary.

For Inpatient admissions, the Medical Review Manager will also certify the number of days of confinement that are considered Medically Necessary. If the attending Health Care Practitioner feels, due to extenuating circumstances, that additional days are required to treat the condition properly, he or she may contact the Medical Review Manager to discuss the Medical Necessity of an extended length of stay and request certification for additional days. Any medical care or confinement that is not determined to be Medically Necessary will not be certified and will not be eligible for benefits.

The Medical Review Manager will promptly notify the Covered Person and the Covered Person's Health Care Practitioner, facility, or supplier, of the outcome of its pre-authorization review determination.

A determination by the Medical Review Manager does not alter, limit, or restrict, in any manner, the attending Health Care Practitioner's ultimate patient care responsibility.

Pre-Authorization Renewal
The Pre-Authorization Process must be repeated if the previously authorized treatment is received more than 30 days after the date Our Medical Review Manager completed review, or if the type of treatment, Health Care Practitioner, or facility differs from what the Medical Review Manager authorized.

To request a renewal of a prior authorization, contact Our Medical Review Manager by calling the toll-free number on the back of Your ID card for pre-authorization. Pre-authorization renewal requests must be made 60 days prior the expiration date of a previously approved pre-authorization request.

Please have all of the following information on hand before calling:

1. The Certificate number for this Plan.

2. The Health Care Practitioner's name, telephone number, fax number, and URL address, if applicable.

3. The service, procedure, and diagnosis code.

4. The proposed date of admission or date the service or procedure will be performed.

5. The facility's name, telephone number, fax number, and URL address, if applicable.

6. The number of the prior pre-authorization for which renewal is requested.

Pre-Authorization/Pre-Service Appeal
If the Covered Person, or his/her Health Care Practitioner, does not agree with the Medical Review Manager's Pre-Authorization Review decision, the Covered Person, a person acting on behalf of the Covered Person, of the Covered Person's Health Care Practitioner has the right to appeal the decision.

A Covered Person is entitled to an immediate appeal if there was a denial involving Prescription Drugs or intravenous infusions.

See the Grievance and Appeal Procedures section of this Certificate for more information.

Reduction of Payment
The pre-authorization requirements are included to assist the Covered Person in obtaining the most appropriate medical care. If the Covered Person does not obtain pre-authorization for the services listed in the When to Call provision, or if the course of treatment is not performed in the manner authorized, the effect of failing to complete the Pre-Authorization process is:

1. Benefits will not be paid for any transplant services that are not pre-authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment, or donor search.

2. Benefits will not be paid for any Specialty Pharmaceuticals that are not authorized by the Medical Review Manager.

3. For other services listed in the When to Call provision, if authorization is not obtained for

the Covered Person's course of treatment, benefits will be reduced for otherwise Covered Charges by 30%, but by no more than $1,000 per course of treatment. Examples of failure to obtain authorization include:

a. The Covered Person fails to obtain authorization for the treatment from the Medical Review Manager.
b. The Covered Person does not contact the Medical Review Manager within the required timeframe.
c. The type of treatment, admitting Health Care Practitioner, or facility differs from what was authorized by the Medical Review Manager.
d. The treatment is Incurred more than 30 days after the Medical Review Manager's review.

The reduced amount, or any portion thereof, will not count toward satisfying any applicable Cost-Sharing.

Concurrent Care Review
For concurrent review determinations to certify an extended stay or additional services, We will notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to You and the provider within one working day after the telephone or electronic notification. The written notification will include the number of days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination for a concurrent review, We will notify by telephone or electronically the provider rendering the service within 24 hours of making the adverse determination, and provide written or electronic notification to You and the provider within one working day of the telephone or electronic notification. The service will continue without liability to You until You have received the determination.

When a Covered Person is receiving treatment, services, or supplies that are subject to concurrent review, We will periodically assess the Medical Necessity and appropriateness of the treatment, services, or supplies throughout the course of treatment. We will notify the Covered Person and their Health Care Practitioner of the outcome of Our concurrent care review.

Continued Stay Review
We may request additional clinical information during an Inpatient confinement. Failure of the Health Care Practitioner or facility to provide the requested information will result in non-authorization of continued Inpatient confinement. No benefits will be considered until the additional information is received by Us.

No benefits will be paid for the days of Inpatient confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Medical Review Manager based on review of the additional information provided.

Retrospective Review
For retrospective review determinations, We will make the determination within 30 working days of receiving all necessary information. We will provide You written notice of Our determination within 10 working days of making the determination.

At Our option, We will retrospectively review the Medical Necessity of claims that are subject to determination of Medically Necessity. If We determine that the treatment, services, or supplies

were Medically Necessary, We will authorize benefits. We will notify the Covered Person and their Health Care Practitioner of the outcome of Our retrospective review.

PROVIDER CHARGES AND MAXIMUM ALLOWABLE AMOUNT PROVISIONS

A Covered Person may use any provider they choose. It is the Covered Person's responsibility to determine if a provider or Pharmacy is participating in the Health Care Provider Network on the date the treatment, services, or supplies are received. To locate a Participating Provider or to verify network status, call the number on Your ID card, or check the directory website identified on the ID card, for assistance. See the Benefit Summary for specific Cost-Sharing levels that apply to each type of provider.

Non-Participating Providers and Non-Participating Pharmacies may bill more than We determine to be a Maximum Allowable Amount and the Covered Person is responsible for payment of any amount billed above the Maximum Allowable Amount.

The Covered Person is not responsible for payment of amounts billed by Participating Providers or Participating Pharmacies in excess of the Contracted Rate for Covered Charges for treatment, services, or supplies received within the Health Care Provider Network.

Payment of Participating Provider or Participating Pharmacy Benefits
Covered Charges for treatment, services, or supplies received from Participating Providers (including Participating Pharmacies) are subject to the Participating Provider (including Participating Pharmacy) Cost-Sharing benefit levels, as shown on the Benefit Summary. To receive payment at the Participating Provider Cost-Sharing level, the Covered Person must meet the requirements for using Participating Providers and must comply with all other Certificate requirements. Covered Charges for treatment, services, or supplies received from Participating Providers are not subject to Maximum Allowable Amount reductions.

Using a Participating Provider or Participating Pharmacy is not a guarantee of coverage. All other requirements of this Plan must be met for Covered Charges to be considered for payment. It is the Covered Person's responsibility to verify a provider's or Pharmacy's status within the Health Care Provider Network at the time of service. If You are having trouble locating a Participating Provider or Participating Pharmacy, call the network's telephone number on Your identification (ID) card.

Facilities must meet accreditation standards in accordance with the Definitions under this Policy. The fact that a facility is listed as participating within the Health Care Provider Network does not guarantee that it meets such standards, or that benefits are payable for services rendered at that facility. Call Us prior to obtaining services to verify if a Participating Provider meets accreditation standards for the services You are seeking.

Maximum Allowable Amounts for Participating Providers and Participating Pharmacies
For goods and services provided by a Participating Provider (including a Participating Pharmacy), the Maximum Allowable Amount is the lesser of billed charges or the Contracted Rate, except that if a Covered Person is covered by Medicare, the Maximum Allowable Amount is the amount Medicare would pay for the goods or services. A Covered Person is not responsible for payment of amounts billed by a Participating Provider or Participating Pharmacy in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.

Payment of Non-Participating Provider and Non-Participating Pharmacy Benefits
Covered Charges for treatment, services, and supplies received from Non-Participating Providers (including Non-Participating Pharmacies) are generally paid at a lower level than

Participating Provider benefits, and are subject to the Non-Participating Provider Cost-Sharing benefit levels, as well as any Maximum Allowable Amount reductions.

Covered Charges for treatment, services, or supplies received from Non-Participating Providers will be processed at the Non-Participating Provider Cost-Sharing level, except as follows:

1. When a Provider's Status Changes
   Providers and Pharmacies may join or leave the Health Care Provider Network at any time. In the event that a Covered Person is under the care of a Participating Provider on the date such Health Care Practitioner's participation in the Health Care Provider Network is terminated, We may pay Covered Charges at the Participating Provider Cost-Sharing level if there are special circumstances.

   Covered Charges will be paid at the Participating Provider Cost Sharing level for the following situations when the Health Care Practitioner's status in the Health Care Provider Network changes from Participating Provider to Non-Participating Provider:

   a. The Covered Person is undergoing a course of treatment for a serious and complex condition and treatment for such condition commenced when the Health Care Practitioner was participating in the Health Care Provider Network;
   b. The Covered Person is undergoing a course of institutional or inpatient care and such care was initiated when the Health Care Practitioner was participating in the Health Care Provider Network;
   c. The Covered Person is scheduled to undergo a Medically Necessary surgical procedure and receive postoperative care related to such surgical procedure and the surgical procedure was scheduled when the Health Care Practitioner was a Participating Provider in the Health Care Provider Network;
   d. The Covered Person is currently pregnant and undergoing a course of prenatal care, including regular prenatal visits, to monitor the pregnancy and such care was initiated with the treating Health Care Practitioner when the provider was participating in the Health Care Provider Network; or
   e. The Covered Person is diagnosed with a terminal illness and the treating Health Care Practitioner began providing treatment to the Covered Person for such terminal illness while a Participating Provider in the Health Care Provider Network.

   In such circumstances, Covered Charges will continue to be paid at the Participating Provider benefit level until the later of the following:

   a. The date 90 days after the effective date of the termination of the Health Care Practitioner's participation in the Health Care Provider Network; or
   b. The date the Covered Person no longer requires Medically Necessary continuous care from such provider.

   If the Covered Person Incurs Covered Charges after a Pharmacy's participation in the Health Care Provider Network has terminated, Covered Charges will be processed according to the Cost-Sharing level of the Pharmacy as of the date the Prescription Order is filled.

2. Receiving Care for Emergency Conditions
   Covered Charges received for Emergency Treatment and Emergency Confinement from

Non-Participating Providers will be paid at the Participating Provider Cost-Sharing level until the Covered Person's condition has Stabilized or after observation for necessary short-term treatment and assessments for the Sickness or Injury has concluded. After the condition has Stabilized and any Medically Necessary observation has concluded, benefits will be paid at the Non-Participating Provider Cost-Sharing level. If possible, We will assist in the Covered Person's transfer to a Participating Provider, if requested by the Covered Person. Following Emergency Treatment and Emergency Confinement, a Covered Person who did not have a choice in providers may receive a bill for the difference between the full amount billed by the provider of services and the Maximum Allowable Amount under this Policy. This is called surprise balance billing. The Covered Person must notify us when this occurs and We will negotiate a settlement with the provider in accordance with state and federal surprise balance billing laws.

3. Receiving Air Ambulance Services
   Covered Charges received for air transportation in an ambulance for a Covered Person from a Non-Participating Provider will be paid at the Participating Provider Cost-Sharing level.

4. Receiving Ancillary Services
   Certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists, or Emergency Room Health Care Practitioners, that are ordered by a Participating Provider may be performed by a Non-Participating Provider.

   Covered Charges for such services rendered by a Non-Participating Provider, when provided in association with direct treatment from a Participating Provider, will be considered at the Participating Provider Cost Sharing level. A Covered Person who did not have a choice in providers may receive a bill for the difference between the full amount billed by the provider of services and the Maximum Allowable Amount under this Policy. This is called surprise balance billing. The Covered Person must notify us when this occurs and we will negotiate a settlement on such billing with the provider in accordance with state and federal surprise balance billing laws.

5. When A Participating Provider Is Not Available
   When a Covered Person does not have reasonable access to a Participating Provider that provides the necessary treatment, services, or supplies within 30 miles (non-rural areas) and 60 miles (rural areas) of their place of residence for primary care and general hospital care, and 75 miles from their place of residence for specialty care and specialty hospitals, Covered Charges will be payable at the Participating Provider Cost Sharing levels for treatment, services, or supplies rendered by a Non-Participating Provider. This does not apply to charges for Prescription Drugs or supplies received from a Non-Participating Pharmacy.

   We will credit Participating Provider Out-of-Pocket Limit by any amount the Covered Person has actually paid the Non-Participating Provider above the Maximum Allowable Amount. The Covered Person must send Us proof of payment for credit to be made.

All Covered Charges for treatment, services, or supplies received from Non-Participating Providers are subject to the Maximum Allowable Amounts for Non-Participating Providers and Non-Participating Pharmacies provision regardless of the Cost-Sharing level We use to process the claim.

Maximum Allowable Amounts for Non-Participating Providers
Providers who have not established a Contracted Rate or Negotiated Rate with Our Network Manager may charge more than We determine to be a Maximum Allowable Amount.

If a Covered Person chooses to obtain covered treatment, services, or supplies from Non-Participating Providers Covered Charges will be limited to what We determine to be the Maximum Allowable Amount.

The Maximum Allowable Amount for goods and services provided by a Non-Participating Provider is the lesser of:

1. Billed charges; or

2. The Negotiated Rate, if available; or

3. 100% of the amount as would be allowed to the provider of a similar type and/or in the same geographic area by CMS if Medicare was the payer (established utilizing the Medicare reimbursement schedules and methodologies) for the same or similar treatment, services or supplies reported on the claim, regardless of whether the provider has agreed to Medicare rates, except We may apply the following alternative percentages:

    a. 140% for facilities or ambulatory surgical centers.
    b. 120% for Health Care Practitioners or providers.
    c. 100% for Diagnostic Imaging and/or laboratory services.
    d. 200% for anesthesia services.
    e. 100% for Durable Medical Equipment and Personal Medical Equipment (including rental).
    f. For emergency services, 140% for facility charges and for physician charges 120%.

The provision for Maximum Allowable Amounts above also applies to Non-Participating Providers performing services at a Participating Provider facility based on the provider category shown above.

Charges from diagnostic imaging providers and laboratory services providers that are Non-Participating Providers but who perform services in connection with a Participating Provider are allowed at 100% of the amount allowed by CMS if Medicare was the payer as described above.

If We determine the Medicare methodology listed above is not suitable or does not exist for that service, We will use normative data and submitted information in accordance with one (1) or more of the following to determine the Maximum Allowable Amount:

a. An estimate of the Medicare-based amount stated above as would be allowed through the use of relative value units or available third party data.
b. The amount a provider of a similar type and/or in the same geographic area bills for the same or similar treatment, services and supplies as reported on the claim, based on a combined profile of derived and actual submitted charge data and relative values.
c. The amount derived by applying comparable markups from providers of a similar type and/or in the same geographic area, to the estimated costs of the provider

providing the treatment, services and supplies reported on the claim, established utilizing the most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS).

d. The expected or estimated charges of providers of a similar type and/or in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, Current Dental Terminology (CDT) codes, or grouping of services as determined through standard Diagnostic Related Groups (DRG), refined DRG, Ambulatory Payment Classification (APC) or other standard industry methodologies, depending upon the services and setting reported on the claim.
e. [The average Contracted Rate [and/or non-Medicare or non-Medicaid Negotiated Rate] amount a Health Care Practitioner, facility, provider, or supplier of a similar type or in the same geographic area has accepted for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted claims data; but, in the case of infusion therapy drugs, not to exceed Average Wholesale Price (AWP), Average Sales Price (ASP), or other nationally recognized drug cost basis used by nationally contracted vendors.]

In reaching a determination as to what amount should be considered as the Maximum Allowable Amount for treatment, services or supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The database used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is adjusted periodically.

[Maximum Allowable Amounts For Established Negotiated Rate
In the event a particular Negotiated Rate has been established with a provider for specific treatment, services, or supplies the Maximum Allowable Amount is always the Negotiated Rate. A Covered Person is not responsible for payment of amounts billed by a provider in excess of the Negotiated Rate in such circumstances.]

MEDICAL BENEFITS

We will pay Covered Charges only for the services and supplies listed as Medical Benefits in this section of the Certificate. How Covered Charges are paid and the Maximum Benefit for the covered services and supplies listed in this section are shown on the Benefit Summary. Refer to the Exclusions section of this Certificate for services and supplies that are not covered under this Plan.

The Covered Person must follow the Pre-Authorization and Other Utilization Review Provisions section and the Provider Charges and Maximum Allowable Amount Provisions section to receive the Maximum Benefits available under this Plan.

The Plan DOES NOT require the designation of a Primary Care Practitioner. You also do not need a referral from the Plan or from any other person (including a Primary Care Practitioner) in order to utilize a Health Care Practitioner who specializes in obstetrics or gynecology or to receive a second opinion regarding a cancer diagnosis. The Health Care Practitioner, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or following a pre-approved treatment plan. If You or Your Covered Dependents are having trouble locating a Participating Provider, use the network website shown on Your Benefit Summary or call the network's phone number on Your identification (ID) card.

After the Covered Person has paid any applicable Cost-Sharing, or any other applicable fees, benefits will be paid by Us for Covered Charges for medical benefits listed in this section for each Covered Person. Any applicable Cost-Sharing or other fees, and the Covered Charges to which they apply, are shown on the Benefit Summary. Benefits are subject to all the terms, conditions, limitations, and exclusions in this Plan

This Plan considers benefits for Behavioral Health and Substance Abuse disorders on the same basis as Sickness.

Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section, unless they are specifically listed as Covered Charges in the Medical Benefits section.

We will consider benefits only for the following Covered Charges:

Inpatient Hospitalization Services
Covered Charges Incurred for:

1. The following services that are provided in a Hospital:

    a. Daily room and board in the most appropriate setting in the Hospital.
    b. Daily room and board in an intensive care setting, such as an Intensive Care Unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and a step-down unit.
    c. Routine nursing services.
    d. Other Medically Necessary services.

    For purposes of this provision, Covered Charges for daily room and board will be considered at a semi-private room rate. Covered Charges for daily room and board in a single or private room will be considered eligible only if a single or private room is

Medically Necessary. If a Hospital has only single or private rooms, Covered Charges will be considered at the least expensive rate for a single or private room. Covered Charges are provided for at least 48 hours of Inpatient care following a mastectomy and at least 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.

Routine well newborn care at birth in a Hospital is covered as described in the Maternity and Newborn Care Services provision, when the newborn is a Covered Dependent.

2. The following transplants:

    a. Kidney.
    b. Cornea.
    c. Skin.
    d. Lung(s).
    e. Heart.
    f. Liver.
    g. Simultaneous kidney/pancreas.
    h. Allogeneic and autologous bone marrow transplant/stem cell rescue.
    i. Chimeric antigen receptor T-cell therapy (CAR T-Cell Therapy) used for FDA approved indications.
    j. Any other transplants that are authorized by Us.

    All transplants must be authorized in advance by Us. The transplant must be for a donated human organ or tissue or an FDA-approved artificial device.

    The transplant benefit applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ. All Covered Charges associated with authorized transplants are covered under this provision, including, but not limited to:

    a. All Inpatient and Outpatient care, facility fees, professional fees, and follow-up care, even though care received on an Outpatient basis may be paid under the Outpatient Medical Services provision.
    b. Prescription Drugs, even though Prescription Drugs received on an Outpatient basis through a Pharmacy may be paid under the Outpatient Prescription Drug Benefits section.
    c. Expenses Incurred for organ search and donor expenses when the recipient is a Covered Person. Organ search means administrative costs for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification, and donor activation. Benefits for donor expenses are available only when the expenses are related to a donation made to a Covered Person.
    d. Expenses Incurred for travel expenses. When a Designated Transplant Provider or Participating Provider is used, authorized travel expenses to obtain the transplant surgery are paid, subject to the Plan's guidelines, for: the Covered Person and one travel companion; and, the donor and one travel companion. For CAR T-Cell Therapy, authorized travel expenses to obtain the CAR T-Cell Therapy are only available when there is no Designated Transplant Provider or Participating
    e. Expenses Incurred for leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for A, B, and DR antigens utilized in bone

marrow transplantation when testing is performed at a licensed facility accredited by the American Association of Blood Banks, College of American Pathologists, American Society for Histocompatibility and Immunogenetics or another national body with requirements at least as stringent as those of the College of American Pathologists. At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Provider available within 100 miles of a Covered Person's place of residence.

Covered Charges for transplants authorized by the Plan include all related medical services Incurred 14 days before the transplant surgery until 365 days after the transplant surgery, or a lesser period not to exceed the termination date of this Plan. All payments for these services are applied toward the transplant benefit.

Transplants with Designated Transplant Provider and Participating Providers:
We have contracted with Designated Transplant Providers to provide transplantation services for specified types of transplants to Covered Persons at a Negotiated Rate.

3. Inpatient services for treatment of Behavioral Health and Substance Abuse disorders when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

Emergency and Ambulance Services
Covered Charges Incurred for:

1. Emergency Treatment for Sickness or Injury. We will pay benefits for Covered Charges Incurred for Emergency Treatment received by a Non-Participating Provider at the benefit level of a Participating Provider. However, services received by a Non-Participating Provider may be subject to Maximum Allowable Amount reductions. Coverage includes the evaluation, treatment to Stabilize, and observation for necessary short-term treatment and assessments for the Sickness or Injury.

   Follow-up visits after the condition has Stabilized will be subject to all the terms, conditions, limitations, and exclusions in this Plan including, but not limited to, any applicable Cost-Sharing for services rendered by Non-Participating Providers and may be subject to Maximum Allowable Amount reductions when services are received from a Non-Participating Provider.

   Covered Charges for services received in an Emergency Room that are not for Emergency Treatment will be paid subject to all the terms, conditions, limitations, and exclusions in this Plan as if the same services had been received in the least intensive setting.

   We will pay benefits for Covered Charges Incurred for Emergency Treatment received outside of the United States at the benefit level of a Participating Provider, in the event such treatment would be covered under this Plan if rendered in the United States. However, services received outside of the United States may be subject to Maximum Allowable Amount reductions. We must receive an English language translation of the claims, medical records, and Proof of Loss, as described in the Claims Provisions section. You are responsible for obtaining this information at Your expense.

Benefits are not payable for any Emergency Treatment rendered in a foreign country in the event the Department of State's Bureau of Consular Affairs has issued Level 3 (reconsider travel) or Level 4 (do not travel) Travel Advisory for U.S. citizens traveling internationally to such foreign country or area, and the Travel Advisory is in effect at the time Emergency Care is received.

2. Professional ground, water, or air transportation in an ambulance for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Hospital that can treat the Sickness or Injury. The ambulance service must meet all applicable state licensing requirements. Benefits for professional ground, water, or air transportation will be considered at the Participating Provider benefit level regardless of the provider's network participation.

3. Medically Necessary non-emergency professional transportation in an ambulance for a Covered Person, when the transport is any of the following:

    a. From a facility that is a Non-Participating Provider, to a facility that is a Participating Provider.
    b. To a Hospital that provides care, services, or treatment that was not available at the original Hospital.
    c. To a more cost-effective Inpatient facility that can provide care, services, or treatment for the Covered Person's Sickness or Injury.
    d. From a facility that provides acute care, to a facility that provides Subacute Medical Care, on an Inpatient basis.
    e. From a facility that provides acute care or Subacute Medical Care on an Inpatient basis, to the Covered Person's home.

    The ambulance service must meet all applicable state licensing requirements.

    Services for non-emergency professional transportation in an ambulance that are provided for convenience are not covered. Charges for non-emergency professional air or water transportation in an ambulance are covered only when terrain, distance, or patient condition warrants.

Outpatient Medical Services
Covered Charges Incurred for:

1. Services performed by a Health Care Practitioner during an Office Visit. For the purpose of this provision, Office Visits include evaluation and management services, as defined in the most recent edition of Current Procedural Terminology, and preventive medicine and wellness services, including, but not limited to, [contraception management], patient education, and counseling. An Office Visit will also include allergy shots and immunotherapy injections of inhaled allergens.

    Office visits do not include laboratory and radiology services, magnetic resonance imaging (MRI), computerized tomography (CT scan), surgical procedures, chemotherapy, allergy testing, a separately billed facility fee, or any other service not specifically listed as a Covered Charge on the Benefit Summary for an Office Visit.

    Although treatment for Behavioral Health and Substance Abuse disorders may occur

during an Office Visit, Covered Charges Incurred for such Office Visits are not considered part of the Office Visit benefit. For coverage of such benefits, see the Outpatient Behavioral Health and Substance Abuse provision.

2. Services performed in a Hospital's Outpatient department, a Free-Standing Facility or an Urgent Care Facility. However, Physical Medicine is covered under the Habilitative and Rehabilitative Services provision in this section.

3. Health Care Practitioner services including, but not limited to, services of a primary surgeon, an Assistant Surgeon or a Surgical Assistant during the surgery. Benefits will be reduced for additional surgical procedures performed in the same operative session.

4. Allergy testing.

5. Oral surgical services for the excision of malignant cysts, tumors, or lesions of the mouth.

6. Anesthesia and the administration of anesthesia.

7. Dental services related to the dental extraction of teeth as a prerequisite of scheduled radiation therapy or covered surgery in accordance with a Dental Treatment Plan.

8. Treatment of a Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums or supporting structures of the teeth. The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable. We reserve the right to limit benefits to the least expensive procedure that will produce a professionally adequate result.

9. The administration of general anesthesia and services in a Hospital or Free-Standing Facility when Dental Treatment is provided to a Covered Person who:

    a. Is a child age 12 or younger and has a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective;
    b. Is severely disabled; or
    c. Has one or more medical or behavioral conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary Dental Treatment or surgery.

    The dental services are not covered, except as otherwise covered in the Child Dental Services provision. Prior authorization for the dental care is required under either the Inpatient Confinements or Outpatient Procedures provision in the Pre-Authorization and Other Utilization Review Provisions section. The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable.

10. Services for removal of tonsils and adenoids.

11. Chemotherapy.

12. Radiation therapy.

13. Routine Patient Costs Incurred by a Qualified Individual while participating in an Approved Clinical Trial.

14. Services to correct or treat Speech and Hearing Disorders including, but not limited to:
    a. Services necessary to identify, assess, diagnose, and consult regarding need for treatment;
    b. Services to evaluate and monitor effectiveness of treatment;
    c. Provision of treatment for any communicative disorders;
    d. Diagnostic and extended evaluation of hearing;
    e. Determinations of range, nature, and hearing function related to auditory efficiency;
    f. Comprehensive behavioral evaluation for sensorineural site;
    g. Testing, adjusting, and evaluating auditory prosthetic devices;
    h. Differentiation between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests;
    i. Planning, directing, conducting, or participating in conservation, habilitative and rehabilitative programs;
    j. Coordinating and consulting with educational, medical and other professional groups, and with patients and their families;
    k. Diagnosing and evaluating speech and language competencies;
    l. Cognitive training secondary to open or closed head injury, regardless of cause;
    m. Assisting individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production;
    n. Evaluating and treating children with delayed or impaired speech or language disorders;
    o. Determination of need for augmentative/prosthetic communication systems, whether or not system or device replaces a body part;
    p. Planning, directing, or conducting habilitative and rehabilitative treatment programs to restore and provide communicative efficiency to individuals with communication problems of organic and nonorganic etiology; and
    q. Other Medically Necessary medical services, health care services, or both for which coverage is:
        i. Provided whether or not for acute conditions;
        ii. Provided while a patient in a hospital; or
        iii. Provided by or in a Subacute Rehabilitation Facility, Skilled Nursing Facility, clinic, Home Health Care Agency or community-based program.

15. Professional services related to the fitting and use of an artificial limb or eye, and orthotic devices.

16. The following services and supplies for the treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction:

    a. Diagnostic services.
    b. Medical services.
    c. Surgical services that are included in a treatment plan authorized by Us prior to surgery.
    d. Removable appliances for TMJ repositioning.
    e. Injection of muscle relaxants.
    f. Therapeutic drug injections.

g. Diathermy therapy.
h. Ultrasound therapy.

17. The following services, equipment, and supplies that are prescribed by a Health Care Practitioner for care and treatment of diabetes, for a Covered Person who has been diagnosed with gestational, type I, or type II diabetes, has elevated blood glucose levels induced by pregnancy, or has another medical condition associated with elevated blood glucose levels.

    a. Routine eye exams.
    b. Routine foot care.
    c. Nutritional counseling.
    d. The following diabetic supplies, equipment, and medication:
        i. Blood glucose monitors, including non-invasive glucose monitors and monitors for use by or adapted for the legally blind.
        ii. Test strips for use with a corresponding glucose monitor.
        iii. Lancets and devices.
        iv. Visual reading strips and tablets that test for glucose, ketones and protein and urine strips and tablets.
        v. Insulin and insulin analog preparations.
        vi. Insulin syringes and injection aids, including devices used to assist with insulin injections and needleless systems.
        vii. Biohazard disposal containers.
        viii. Insulin pumps, both external and implantable, and associated appurtenances, which include: insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies.
        ix. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
        x. Medications available with or without a prescription for controlling the blood sugar level.
        xi. Podiatric appliances, for the prevention of complications associated with diabetes, including up to 2 pairs of therapeutic footwear (including inserts provided with the shoes) per Year.
        xii. Glucagon emergency kits.
        xiii. As new or improved treatment and monitoring equipment becomes available and is approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be appropriate by the treating Health Care Practitioner through a written order.
    e. Diabetes outpatient self-management training prescribed and performed by a Health Care Practitioner for:
        i. The development of an individualized management plan created for and in collaboration with the Covered Person; and
        ii. Medical nutritional counseling and instructions on the proper use of diabetes equipment and supplies.

Self-management training will be provided to the Covered Person or to a caretaker for the Covered Person upon:

- The initial diagnosis of diabetes;
- A written order of a Health Care Practitioner indicating that a significant change in the Covered Person's symptoms or condition requires changes in the Covered Person's regime; or
- A written order of a Health Care Practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

For the purpose of the self-management training, a "caretaker" means a family member or significant other of the Covered Person who is responsible for ensuring that a Covered Person, who is not able to manage his or her diabetes due to age or infirmity, is properly managed, including oversight of diet, administration of medications and use of equipment and supplies.

Benefits for insulin, insulin analog preparations, syringes, needles, lancets testing agents, injection aids, medications for controlling blood sugar level, glucagon emergency kits, and items listed above that are dispensed from a Pharmacy, are covered under the Outpatient Prescription Drug Benefits section. For other diabetic equipment and supplies benefits, see the Durable Medical Equipment and Personal Medical Equipment provision in this section.

18. Foot care for a Covered Person with peripheral vascular disease, peripheral neuropathy, circulatory disorders in the lower extremities, or chronic arterial or venous insufficiency.

19. Growth hormone therapy treatment, diagnosis, or supplies, including drugs and hormones, only when such treatment is clinically proven to be effective for any of the following conditions:

    a. Growth hormone deficiency, as confirmed by documented laboratory evidence.
    b. Growth retardation secondary to chronic renal failure before or during dialysis.
    c. AIDS wasting syndrome.

    Growth hormone treatment must be likely to result in a significant improvement in the Covered Person's condition.

20. Telemedicine Services and Telehealth Services rendered by a Health Care Practitioner.

21. Reconstructive Surgery:

    a. To restore function for conditions resulting from an Injury.
    b. That is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part.
    c. Following a Medically Necessary mastectomy. Reconstructive Surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas.
    d. Because of a congenital Sickness or anomaly of a covered child that resulted in a functional defect.

Cosmetic Services and services for complications from Cosmetic Services are not covered regardless of whether the initial surgery occurred while the Covered Person was covered under this Plan or under any previous coverage.

22. Intravenous injectable parenteral drug therapy services for total parenteral nutrition and other fluids, blood and blood products, and medications requiring a written prescription that would be administered intravenously.

    Services include infusion therapy services that are provided in a Covered Person's home on an Outpatient basis, for the administration of fluids, nutrition, or medication (including all additives or chemotherapy) by intravenous or gastrointestinal (enteral) infusion, or by intravenous injection.

    The first dose of infusion therapy may be given on an Outpatient basis at the Health Care Practitioner's facility of choice, including a Hospital, Free-Standing Facility, or in a Covered Person's home. Any subsequent dose may also be given at the Health Care Practitioner's facility of choice, but only at the most appropriate, cost effective site of care.

    For Specialty Pharmaceutical benefits, see the Outpatient Prescription Drug Benefits section.

23. Non-Intravenous injectable parenteral drug therapy services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection.

    If the injectable drug is covered under the Medical Benefits section, any administration fees are covered under the Outpatient Medical Services provision in this section when the injectable drug is received on an Outpatient basis through a method other than self-administration. For insulin injection and Specialty Pharmaceutical benefits, see the Outpatient Prescription Drug Benefits section.

24. Enteral formulas for home use for the treatment of phenylketonuria (PKU) and inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism, as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period who are less than 6 years of age. Please note that, for the purposes of this section, "low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Health Care Practitioner for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

25. Amino acid-based elemental formulas, regardless of the formula delivery method, for the diagnosis and treatment of:

    a. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
    b. severe food protein-induced enterocolitis syndrome.
    c. eosinophilic disorders, as evidenced by the results of a biopsy.
    d. impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

26. Chronic disease management.

27. Outpatient services for Behavioral Health and Substance Abuse disorders when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program, or by a Health Care Practitioner who is licensed to treat Behavioral Health or Substance Abuse in an office setting. Benefits for Office Visits related to Behavioral Health or Substance Abuse disorders will be considered in accordance with the Outpatient Behavioral Health or Substance Abuse Benefit as shown on the Benefit Summary. For benefits prescribed for the treatment of Behavioral Health and Substance Abuse, see the Outpatient Prescription Drug Benefits section.

Clinical Preventive Services
Covered Charges Incurred for services provided for the following categories of preventive treatment required under the Affordable Care Act (ACA) (detailed information is available at [www.healthcare.gov]):

1. Evidence-Based Screenings and Counseling
   Evidence-based items or services for preventive care that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

   For more information about the evidence-based items or services that are covered under this Plan, refer to the USPSTF's current recommendations posted at: [https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations].

   This includes:
   - A pelvic examination and Pap smear for any nonsymptomatic woman, in accordance with the current American Cancer Society guidelines;
   - A prostate examination and laboratory tests for cancer for any nonsymptomatic man, in accordance with the current American Cancer Society guidelines; and
   - A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Covered Person, in accordance with the current American Cancer Society guidelines.

2. Routine Immunizations
   Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, in accordance with the appropriate immunization schedule with respect to the Covered Person involved.

   For more information about the routine immunizations covered under this Plan, refer to the CDC's schedule of immunizations posted at: [http://www.cdc.gov/vaccines/schedules/index.html].

3. Preventive Pediatric Health Care Services
   For infants, children, and adolescents, evidence-informed preventive screenings and assessments provided for in the comprehensive guidelines published by the American

Academy of Pediatrics (AAP) and supported by the Health Resources and Services Administration (HRSA), in accordance with the recommended periodicity schedule of screenings and assessments applicable to the Covered Person involved.

The preventive services to be covered for infants, children, and adolescents (birth to 18 years of age) include immunization and screening services to the extent they are not covered within the previous two categories as well as Child Health Supervision Services.

This does not include routine well newborn care at birth. For more information about routine well newborn care covered under this Plan, refer to the Maternity Care Services provision in this section.

For more information about the preventive pediatric health care services covered under this Plan, refer to the AAP's periodicity schedule of screenings and assessments posted at: [https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf].

For the purposes of this benefit, Child Health Supervision services means the periodic review of a child's physical and emotional status by a physician or pursuant to a physician's supervision. A review shall include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards which includes coverage from the moment of birth through age 12 at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, and 12 years.

4. Preventive Health Care Services For Women
   For women, evidence-informed preventive care and screening provided for in the women's comprehensive preventive services guidelines supported by the HRSA, to the extent not already included in other recommendations of the USPSTF and/or HRSA.

   For more information about the preventive health care services for women covered under this Plan, refer to the HRSA's Women's Preventive Services' Guidelines posted at: [https://www.hrsa.gov/womens-guidelines-2019].

5. Mammography Screening
   To the extent not already included as Clinical Preventive Services in other recommendations of the USPSTF and/or HRSA, annual screening by low-dose mammography for the presence of occult breast cancer for a Covered Person who is age 35 to 39, an annual mammogram for a Covered Person who is 40 or older, and an annual mammogram for women with above-average risk for breast cancer in accordance with the American College of Radiology guidelines, and an annual diagnostic mammogram for the presence of occult breast cancer for a Covered Person. The following are also included for breast cancer screening and evaluation when Medically Necessary and in accordance with the American College of Radiology guidelines:
   - Additional or supplemental imaging (e.g., breast MRI or ultrasound); and
   - Ultrasound or MRI services for any woman deemed to have above-average risk for breast cancer.

   For purposes of this benefit, the following definitions apply:

- Low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, cassettes, digital mammography and breast tomosynthesis (3D mammography), with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.
- Diagnostic mammogram means an imaging examination designed to evaluate:
  - a subjective or objective abnormality detected by a physician in a breast;
  - an abnormality seen by a physician on a screening mammogram;
  - an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
  - an individual with a personal history of breast cancer.

Cost-Sharing will not be required for Clinical Preventive Services when You use a Participating Provider. If You use a Non-Participating Provider to obtain these services, You will be responsible for any applicable Cost-Sharing, as shown on the Benefit Summary, and any amount that exceeds the Maximum Allowable Amount.

When changes are made to the recommendations or guidelines for covered clinical preventive categories listed above, benefits for the new or changed Clinical Preventive Services will be provided for Plan Years that begin on or after the date that is one (1) year after the date the recommendation or guideline is issued or amended.

Preventive Medicine and Wellness Services
Covered Charges Incurred for preventive medicine and wellness services, to the extent such services are not already covered under this Plan pursuant to the Clinical Preventive Services provision. Such services may include, but are not limited to, the following:

1. Prostate specific antigen screening.

2. Complete blood count (or component parts) testing.

3. Urinalysis testing.

Cost-Sharing applies to these preventive medicine and wellness services, as shown on the Benefit Summary.

Diagnostic Imaging Services and Laboratory Services
Covered Charges Incurred for:

1. Diagnostic Imaging services and laboratory services.

2. Interpretation of Diagnostic Imaging services and laboratory tests if a written report with interpretation is produced directly by the Health Care Practitioner.

3. Genetic testing to diagnose current symptoms of a potential hereditary disease.

4. Screening for lead poisoning, as follows:
   a. Annual blood sample screening for children less than six years of age; and
   b. A blood sample screening for pregnant women.

Autism Spectrum Disorder and Applied Behavior Analysis Services
Covered Charges Incurred for diagnosis and treatment of autism spectrum disorders and for diagnosis and treatment of developmental or physical disabilities. Coverage is limited to Medically Necessary treatment ordered by a treating, licensed physician or psychologist within the scope of license and in accordance with a Qualified Treatment Plan.

Habilitative and rehabilitative care, including applied behavior analysis therapy for autism spectrum disorder diagnosed individuals is covered under the Habilitative and Rehabilitative Services benefit.

Habilitative and Rehabilitative Services
Covered Charges Incurred for the following Habilitative Services and Rehabilitative Services:

1. Outpatient Physical Medicine and Habilitative Services listed below that are provided in an Outpatient setting, or in a Covered Person's home (by a licensed or certified agency) on an Outpatient basis. Services must be rendered by a licensed speech therapist or pathologist, occupational or physical therapist, chiropractor, audiologist, doctor, psychologist, applied behavioral analysis therapist, or social worker.

    a. Physical Therapy, Occupational Therapy, and Speech Therapy which includes early intervention services for Covered Dependents from birth to age 3 who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq..
    b. Pulmonary rehabilitation programs.
    c. Adjustments, and manipulations and massage therapy.
    d. Cardiac Rehabilitation Programs.
    e. Services for treatment of Developmental Delay.
    f. Applied behavioral analysis.

    Services provided for educational purposes, services provided in a school setting, and educational services available to the Covered Person under local, state, or federal law are not covered. Covered Charges do not include charges for services focused on developing or building communication skill or social interaction or protocol skills, except as otherwise provided for during applied behavior analysis therapy.

    We will require a Qualified Treatment Plan (QTP) before benefits are considered. We will also require periodic review of the QTP and progress made. We may amend authorization for the treatment or frequency of care based on Our Medical Necessity review of continued care.

    Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued as determined by Us.

2. Home Health Care services including:

    a. Home Health Care visits by a licensed nurse.
    b. Home Health Care visits by a home health aide under the supervision of a licensed nurse.
    c. Respiratory therapy or inhalation therapy.
    d. Physical Therapy, Occupational Therapy, and Speech Therapy.
    e. Intravenous injectable parenteral drug therapy when authorized by Us to be paid

under the Medical Benefits section.
f. Non-intravenous injectable drug therapy when authorized by Us to be paid under the Medical Benefits section.

Home Health Care must be provided by a Home Health Care Agency. One visit consists of up to 4 hours of care within a 24-hour period by anyone providing services or evaluating the need for Home Health Care. We require a Qualified Treatment Plan (QTP) before benefits are considered. We may also require periodic review of the QTP and progress made. We may amend authorization for the treatment or frequency of care based on Our Medical Necessity review of continued care.

Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued, as determined by Us.

3. Inpatient Rehabilitative Services, including services provided in an Acute Medical Rehabilitation Facility, that include, but are not limited to:

    a. Rehabilitative Services provided for the same or a related Sickness or Injury that required an Inpatient Hospital stay.
    b. Treatment of complications of the same or a related condition that required an Inpatient Hospital stay.
    c. Physical Therapy, Occupational Therapy, and Speech Therapy.
    d. Pulmonary rehabilitation programs.
    e. The evaluation of the need for the services listed above.

    We require a Qualified Treatment Plan (QTP) before benefits are considered. We may also require periodic review of the QTP and progress made. We may amend authorization for the treatment or frequency of care based on Our Medical Necessity review of continued care.

    Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued as determined by Us.

4. Subacute Rehabilitation Facility and Skilled Nursing Facility care, including services provided in a Subacute Rehabilitation Facility or Skilled Nursing Facility that are provided in lieu of care in a Hospital.

    We require a Qualified Treatment Plan (QTP) before benefits are considered. We may also require periodic review for the QTP and progress made. We may amend authorization for the treatment or frequency of care based on Our Medical Necessity review of continued care.

    Coverage will cease when measurable and significant progress toward expected outcomes has been achieved or has plateaued as determined by Us.

Hospice Services
Covered Charges Incurred for:

1. The following Inpatient services when confined in a Hospice facility:

    a. Daily room and board.

b. Part-time or intermittent nursing care by or under the supervision of a licensed registered nurse.
c. Other Hospice services and supplies.

2. The following home care services when care is provided by a licensed Hospice:

    a. Part-time or intermittent nursing care by or under the supervision of a licensed registered nurse.
    b. Other Hospice services and supplies.
    c. Counseling services by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person prior to another Covered Person's death.
    d. Bereavement counseling by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person after another Covered Person's death.

Durable Medical Equipment and Personal Medical Equipment
Covered Charges Incurred for:

1. Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:

    a. A wheelchair.
    b. A basic Hospital bed.
    c. Basic crutches.

2. Casts, splints, and trusses.

3. Orthotic devices that are custom-fitted or custom-fabricated to correct a deformity, improve function, or relieve symptoms of a disease. Custom knee braces will be covered only when a customization is Medically Necessary.

4. The temporary interim and initial permanent basic artificial limb or eye. Coverage also includes related services, such as design, fabrication and customization of the device; necessary visits and fittings to ensure proper fit and use of device; necessary modifications due to physical changes; and periodic evaluation and care to ensure fit and function.

5. External breast prostheses needed because of surgical removal of all or part of the breast.

6. Oxygen and the equipment needed for the administration of oxygen.

7. The initial hair prosthesis worn for hair loss caused by: chemotherapy or radiation treatment for diagnosis of cancer; or diagnosis of alopecia areata.

8. Hearing aids for:
    a. Newborns, as well as initial amplification after newborn hearing screenings.
    b. Children covered und MO HealthNet who are 18 years of age and under.

9. Assistive technology devices for Covered Dependents from birth to age 3 who are identified

by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.

10. Prosthetic devices which replace all or part of an internal body organ; leg, arm, back, and neck braces; and artificial legs, arms, and eyes.

11. Other Durable Medical Equipment and supplies that are approved in advance by Us.

Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of wheelchairs, artificial limb or eye, and orthotic or prosthetic devices will be covered when authorized by Us before any equipment is purchased.

Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of any of the items listed above, other than wheelchairs, artificial limb or eye, and orthotic devices, are not covered, regardless of when the item was originally purchased.

Replacements due to outgrowing wheelchairs or Durable or Personal Medical Equipment as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased.

Charges for duplicate wheelchairs or other Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.

For benefits related to the fitting and use of orthotic devices, artificial limb, or artificial eye, see the Outpatient Medical Services provision in this section.

Maternity and Newborn Care Services
Covered Charges Incurred for:

1. Prenatal care in accordance with the A and B recommendations of the United States Preventive Services Task Force (USPSTF) are considered under the Clinical Preventive Services provision.

2. Delivery for a minimum of 48 hours of Inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of Inpatient care following an uncomplicated caesarean section delivery.

3. Postpartum care, including but not limited to: a postpartum physical assessment of both the mother and newborn; the performance of any Medically Necessary clinical tests and immunizations including newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification; and, two post-discharge visits with a registered professional nurse per delivery, of which at least one must be a home visit.

4. Routine well newborn care, including nursery charges, from the moment of birth until the mother is discharged from the Hospital. Except for the delivery charge itself, the newborn will be considered distinct from the mother for purposes of benefit eligibility and coverage.

5. Circumcision for newborn males.

6. Complications of Pregnancy.

Specialty Pharmaceutical Services
Covered Charges Incurred for Specialty Pharmaceuticals that are parenteral drugs, when they are administered, dispensed, or received on an Outpatient basis through a method other than self-administration. To be covered under this Plan, Specialty Pharmaceuticals must be authorized by the Plan in accordance with the Pre-Authorization and Other Utilization Review Provisions and any applicable Specialty Pharmacy Program.

For a Covered Person's first-time use of any Specialty Pharmaceutical, we may limit Our authorization to an initial 15-day treatment regimen. If the treatment regimen is continued, additional supply may be authorized.

If the Specialty Pharmaceutical is covered under this Medical Benefits section, any administration fees are covered under the Outpatient Medical Services provision when the Specialty Pharmaceutical is received on an Outpatient basis through a method other than self-administration.

For insulin injection benefits, and benefits for Specialty Pharmaceuticals that are oral medications or that are obtained through a Pharmacy for self-administration, see the Outpatient Prescription Drug Benefits section.

[Telehealth Vendor] Services
Covered Charges Incurred for a virtual visit which include services performed electronically, through [Telehealth Vendor] medical providers or licensed therapists, outside of a medical facility. The virtual visit permits two-way, real-time interactive audio and/or video communication between the Covered Person and a Health Care Practitioner at a distant location.

For purposes of this benefit, a [Telehealth Vendor] visit includes the following types of visits:

- [Telehealth Vendor] Urgent Care Visit – A meeting between a Covered Person and licensed provider to diagnose, treat and prescribe medication (when Medically Necessary) for a Covered Person's non-emergency medical condition.
- [Telehealth Vendor] [Virtual Counseling] Visit – A meeting between a Covered Person, age [1-18] years old and up, and a licensed therapist to provide assistance with a Covered Person's mental and emotional health concerns.
- [Telehealth Vendor] [Psychiatry] Visit – A meeting between a Covered Person, age [1-18] years old and up, and a licensed psychiatrist to provide assistance with a Covered Person's mental and emotional health concerns.

Covered Charges associated with a [Telehealth Vendor] visit are paid as shown in the Benefit Summary.

Please access the [Telehealth Vendor] website at [web address] to receive additional information on [Telehealth Vendor] visits. You may call [Telehealth Vendor] at [XXX.XXX.XXXX].

Benefits for Telehealth or Telemedicine Services provided by a Health Care Practitioner that is not a part of [Telehealth Vendor] are covered under the Outpatient Medical Services benefit. Services rendered by other internet-based telemedicine companies other than [Telehealth Vendor] will not be considered Covered Charges, and will not be paid.

Charges for Prescription Drugs prescribed during a [Telehealth Vendor] Urgent Care Visit by the

treating [Telehealth Vendor] providers are covered under the Outpatient Prescription Drug Benefits section.

[Telehealth Vendor] visits are not appropriate for a medical, mental health, or behavioral health emergency. If you are experiencing a medical emergency or crisis situation, dial 911 immediately for assistance.

Child Vision Services
This provision provides benefits only for Covered Persons age 18 or younger. This benefit terminates as of the last day of the month in which the Covered Person turns 19 years of age. Vision services and equipment charges Incurred on or after the first day of the first month following the Covered Person's 19th birthday are not eligible for benefits under this Plan.

When a Covered Person seeks to obtain services, the Covered Person must select a Designated Eyewear Provider for exam and eyewear coverage, schedule an appointment, and inform the Designated Eyewear Provider that he/she is a Covered Person through Our Eyewear Benefit Manager. If a Covered Person receives services from a Non-Participating provider the services and applicable Cost-Sharing are considered at the Non-Participating Provider benefit level.

Covered Charges Incurred by Covered Persons age 18 or younger for the following:

1. Routine eye exams, including new and established patient exams and routine ophthalmologic exams with refraction. Includes dilations, if clinically indicated.

   Preventive child vision screenings are considered under the Clinical Preventive Services provision in this section.

2. Eyewear, limited to the Covered Person's choice, per Year of either:

   a. One pair of glasses. Benefit includes both frames and lenses, including glass, plastic or polycarbonate lenses, of all lens powers, with or without scratch resistant coating and ultraviolet protective coating; or
   b. Prescription contact lenses. Benefits include contact lenses (materials), evaluation, materials, fitting, and follow-up care. Contact lenses are covered for the following modalities as shown below:
      i. Standard contact lenses –one pair annually.
      ii. Monthly contact lenses – 6-month supply.
      iii. Bi-weekly – 3-month supply.
      iv. Daily – 3-month supply.

   Necessary contact lenses are a Plan Benefit when specific benefit criteria, such as certain eye conditions, are satisfied, and when prescribed by a Health Care Practitioner.

   Replacement lenses within the same Year are not covered.

   To be considered Participating Provider benefits, eyewear must be purchased from a Designated Eyewear Provider and the eyewear must be part of the Pediatric Eyewear Collection designated by Our Eyewear Benefit Manager. Any eyewear that is purchased from a provider other than a Designated Eyewear Provider is considered at the Non-Participating Provider benefit level, and is subject to any Maximum Allowable Amount or

Maximum Benefit limitations applicable for Non-Participating Provider exam and eyewear benefits.

3. One comprehensive low vision evaluation every 5 years. Low vision examinations must be pre-authorized.

4. Follow up care for low vision services, limited to 4 visits in any 5-year period.

5. Low vision optical devices including low vision services, and an assistive low vision aid when follow-up care is pre-authorized. Benefits are limited to one every 2 Years.

6. High power spectacles, magnifiers, and telescopes if Medically Necessary.

Child Dental Services
This provision provides benefits only for Covered Persons age 18 or younger. This benefit terminates as of the last day of the month in which the Covered Person turns 19 years of age. Dental services charges Incurred on or after the Covered Person's 19th birthday are not eligible for benefits under this Plan, except as otherwise covered in the Outpatient Medical Services provision.

If a program of Dental Treatment is already in progress on the Covered Person's Effective Date, only those services and supplies Incurred on or after the Effective Date will be covered by this Plan. No payment will be made for Dental Treatment completed after Your, or a Covered Dependent child's, coverage under the Plan ends, except as otherwise provided by this Plan.

Dental Treatment must be:

1. performed by or under the direction of a Dentist, or performed by a Dental Hygienist or Denturist; and

2. Medically Necessary.

We consider Dental Treatment to be started as follows:

1. Full or partial denture	The date the first impression is taken.
2. Fixed bridge, crown, inlay or onlay	The date the teeth are first prepared.
3. Root canal therapy	The date the pulp chamber is first opened.
4. Periodontal surgery	The date the surgery is performed.
5. All other Dental Treatment	The date Dental Treatment is rendered.

We consider Dental Treatment to be completed as follows:

1. Full or partial denture	The date a final completed appliance is first inserted in the mouth.
2. Fixed bridge, crown, inlay or onlay	The date an appliance is cemented in place.

3.	Root canal therapy	The date a canal is permanently filled.

We consider Dental Treatment to be started and completed on the date Dental Treatment is rendered. See Class IV: Orthodontic Dental Services for start and completion dates for Orthodontic Treatment.

Claims submitted to Us must identify the Dental Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request existing X-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

We consider a temporary Dental Treatment to be an integral part of the final Dental Treatment. The sum of the fees for temporary and final Dental Treatment will be used to determine whether the charges are above the Maximum Allowable Amount.

We will consider benefits only for the following Covered Charges Incurred by Covered Persons who are age 18 or younger during the current Plan Year. No other routine dental benefits are covered under this provision.

To find applicable Cost-Sharing associated with Your Plan, please visit [www.allstatebenefits.com].

Class I: Preventive Dental Services

1. Periodic or comprehensive oral evaluations, limited to 1 time in any 6-month period.
2. Comprehensive periodontal evaluation, limited to 1 time in any 6-month period.
3. Intra-oral complete series of radio graphic images.
4. Intraoral periapical X-rays.
5. Intraoral occlusal X-rays.
6. Extraoral X-rays, limited to 1 film in any 6-month period.
7. Bitewing X-rays, limited to 1 set in any 6-month period.
8. Dental prophylaxis, limited to 1 time in any 6-month period.
9. Topical fluoride treatment (excluding prophylaxis) or topical fluoride varnish, limited to 2 times in any 12-month period.
10. Sealant applications made to the Occlusal surface of permanent molar teeth.
11. Preventive resin restorations for a permanent tooth for Covered Person with moderate to high caries risk.
12. Space maintainers (including re-cementation and all adjustments made within 6 months of installation), limited to Covered Persons age 18 or younger.

Class II: Basic Dental Services

1. Limited oral evaluation (problem focused), considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit. Limited to 1 time in every 6-month period.

2. Other X-rays (except films related to orthodontic procedures or Temporomandibular Joint Dysfunction).

3. Stainless steel crowns for teeth not restorable by an amalgam or composite filling, limited to: 1 time in any 60-month period and Covered Persons age 14 or younger.

4. Pulpotomy.

5. Pulpal therapy (resorbable filling) on either anterior or posterior primary teeth, limited to primary incisor teeth for Covered Persons age 6 or younger; limited to primary molars and cuspids for Covered Persons age 10 or younger. Maximum Benefit of one pulpal therapy per tooth, per Covered Person. Excludes final restoration.

6. Oral surgery services as listed below, and routine post-operative care:

    a. Surgical extractions (including extraction of wisdom teeth).
    b. Alveolplasty.
    c. Coronectomy.
    d. Vestibuloplasty.
    e. Removal of exostosis (maxilla or mandible).
    f. Removal of impacted tooth.
    g. Incision and drainage of intraoral soft tissue abscess.
    h. Suture of recent small wounds.
    i. Surgical access of unerupted tooth
    j. Excision of pericoronal gingiva.

7. Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.

8. Simple extraction.

9. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

10. Incision and drainage of abscess.

11. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit.

12. General anesthesia and intravenous sedation. Coverage for general anesthesia will be considered for payment based on the benefit allowed for the corresponding intravenous sedation. Coverage is considered for payment as a separate benefit only when Medically Necessary and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Plan.

13. Amalgam restorations, primary or permanent.

    a. Multiple restorations on one surface will be considered a single filling.

b. Replacement of an existing amalgam restoration.
c. Mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations.

14. Silicate restorations.

15. Protective restorations.

16. Plastic restorations.

17. Composite restorations, resin-based.

    a. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restoration.
    b. Acid etch is not covered as a separate procedure.
    c. Replacement of an existing composite restoration.

18. Pin retention restorations, covered only in conjunction with an amalgam or composite restoration.

19. Periodontal scaling and root planning (per quadrant), limited to 1 every 24 months.

20. Periodontal Maintenance Procedure (following active Dental Treatment of adult prophylaxis), not to exceed 4 in any 12-month period.

Class III: Major Dental Services

1. Consultation, including specialist consultations:

    a. Coverage is considered for payment only if billed by a Dentist who is not providing operative Dental Treatment.
    b. Coverage will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.

2. Detailed and extensive oral evaluation (problem focused), considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit.

3. Therapeutic drug injections.

4. All benefits for inlays, onlays, crowns, dentures, implants, and fixed bridges include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

5. Root canal therapy (anterior, bicuspid, molar), including all pre-operative, operative and post- operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care

6. Apexification and recalcification.

7. Pulpal regeneration (regenerative treatment for an immature permanent tooth with necrotic pulp), not including final restoration.

8. Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

9. Root amputation (per root).

10. Hemisection, including any root removal and an allowance for local anesthesia and routine post- operative care. Coverage does not include a benefit for root canal therapy.

11. Periodontal related services as listed below, limited to 1 every 36 months per service category:

    a. Gingivectomy or gingivoplasty; gingival flap procedure;
    b. Osseous surgery;
    c. Osseous grafts.

12. Periodontal related services as listed below:

    a. Subepithelial connective tissue graft;
    b. Pedical grafts;
    c. Tissue grafts;
    d. Full mouth debridement for comprehensive evaluation and diagnosis.

13. Periodontal appliances, limited to 1 appliance per Year.

14. General anesthesia and intravenous sedation, limited as follows: considered for payment as a separate benefit only when Medically Necessary and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under this Plan. Coverage for general anesthesia will be considered for payment based on the benefit allowed for the corresponding intravenous sedation.

15. Inlays.

16. Onlays.

17. Porcelain restorations on anterior teeth.

18. Crowns, limited to 1 every 60 months.

19. Recementing inlays.

20. Recementing crowns.

21. Crown lengthening when Medically Necessary.

22. Crown build-up, including pins and prefabricated posts; limited to 1 per tooth every 60 months.

23. Post and core, covered only for endodontically treated teeth requiring crowns; limited to 1 every 60 months.

24. Core buildup, including pins.

25. Prefabricated abutment.

26. Implant or abutment supported connecting bars.

27. Endodontic endosseous implant and endosseous implant.

28. Implant index and implant removal; limited to 1 every 60 months.

29. Implant maintenance procedures or repair to implant prosthesis.

30. Full dentures.

    a. We will not pay additional benefits for personalized dentures or overdentures, or associated Dental Treatment.
    b. We will not pay for any denture until it is accepted by the Covered Person.

31. Partial dentures, including any clasps and rests and all teeth. Includes precision or semi-precision attachments.

32. Each additional clasp and rest.

33. Retainers, including abutment or implant supported retainers or cast metal or porcelain/ceramic retainers for resin bonded fixed prosthesis; limited to 1 per tooth every 60 months.

34. Denture adjustments.

35. Repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12-months after the initial insertion.

36. Relining, recementing, or rebasing dentures, limited to 1 time in any 36-month.

37. Tissue conditioning.

38. Fixed bridges (pontics), including Maryland bridges, limited to 1 every 60 months.

    a. Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 60 months old and cannot be made serviceable.
    b. We will not pay benefits for a fixed bridge replacing the extracted portion of a hemisected tooth.

39. Recementing bridges, limited to repairs or adjustments performed more than 12 months after the initial insertion of the bridge.

40. Non-surgical temporomandibular joint (TMJ) treatment for: myofascial pain syndrome; muscular, neural, or skeletal disorder; and dysfunction or disease of the temporomandibular joint.

Benefits include Dental Treatment of the chewing muscles to relieve pain or muscle spasm, X-rays, and occlusal adjustments.

Benefits do not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing.

Class IV: Orthodontic Dental Services
Orthodontic Treatment is covered only when such treatment is Medically Necessary. Orthodontic Treatment for cosmetic purposes is not covered under this Plan.

We will consider benefits only for the following Covered Charges Incurred by Covered Persons who are age 18 or younger during the current Plan Year:

1. Cephalometric X-rays. oral or facial photographic images used in Orthodontic Treatment.

2. Diagnostic casts (study models), limited to casts made for orthodontic purposes.

3. Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes.

4. Orthodontic appliances for tooth guidance.

5. Fixed or removable appliances to correct harmful habits.

Benefits for Orthodontic Treatment are not payable for expenses Incurred for retention of orthodontic relationships. Benefits for Orthodontic Treatment are payable only for active Orthodontic Treatment for the services listed above.

We will pay benefits for the orthodontic services listed above for those parts of the Dental Treatment Plan Incurred while the Covered Person is insured under the Plan. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.

We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care, and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered orthodontic services will be paid in equal monthly installments over the course of the remaining Orthodontic Treatment. The benefit consideration for the initial Orthodontic Treatment and monthly installments will be determined as follows:

1. An initial amount of 25% of the Covered Charges for the Orthodontic Treatment charge will be considered for the initial Orthodontic Treatment. This amount will be considered Incurred as of the date appliances or bands are inserted.

2. The remaining 75% of the benefit consideration will be divided by the number of months that Orthodontic Treatment will continue to determine the amount that We will consider Incurred for each subsequent month of Orthodontic Treatment. The subsequent monthly benefits will be considered only if the Covered Person receiving treatment remains covered under the Plan and provides proof to Us that Orthodontic Treatment continues.

If Orthodontic Treatment began prior to the Effective Date of coverage, We will consider benefits only for those portions of Orthodontic Treatment Incurred after the Effective Date.

Alternate Medical Care Plan
We may provide benefits for alternate medical care. Alternate medical care is a special arrangement that is made with You, Your Health Care Practitioner, and Us to provide services to the Covered Person, which may exceed a maximum limit for a specific benefit in exchange for the exhaustion of a specified amount of another benefit that is covered under this Plan.

To be considered for alternate medical care, the Covered Person must be participating in case management services provided by Our designee or Us. Alternate medical care must:

1. Be approved in writing by You and the Covered Person's Health Care Practitioner; and

2. Be approved in writing by Us.

We will pay the mutually agreed upon amount for the specified alternate medical care based on the terms set forth in the signed written alternate medical care agreement approved by Us. However, We will not pay for any alternate medical care services Incurred or received prior to Our written approval of the alternate medical care. Any alternate medical care benefits that We pay will apply toward the Covered Person's Plan limits.

Providing benefits for alternate medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this Plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations and exclusions of this Plan at any other time or for any other insured person, whether or not the circumstances are similar or the same.

Specialized Medical Care Plan
We may provide benefits for specialized care approved in advance by Us under Our Specialized Medical Care Program. Benefits under a Specialized Medical Care Plan may be offered on a one-time basis or for a designated period. A Specialized Medical Care Plan may provide services or supplies that: 1) coordinate with a Covered Person's Medically Necessary treatment, and/or 2) facilitate or assist in the support of such treatment. Such benefits may be provided to the Covered Person or the Covered Person's family members or caregivers as outlined in the Specialized Medical Care Plan. A Specialized Medical Care Plan may also include waiver of all or a portion of the Covered Person's Cost-Sharing obligations for such Covered Charges or provide increased benefits.

To be considered for a Specialized Medical Care Plan, the Covered Person must be participating in case management or disease management services provided by Our designee or Us.

We will not pay for any specialized medical care services or supplies Incurred or received prior to Our approval of the Specialized Medical Care Plan, or after the designated timeframe in the Specialized Medical Care Plan expires.

Providing benefits for specialized medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this Plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations, and exclusions of

this Plan at any other time or for any other Covered Person. The Specialized Medical Care Program may be discontinued at any time. Any approved benefits will be administered to the end of the period for which they had been approved under the Specialized Medical Care Plan.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Only the Prescription Drugs listed on Our Drug List and received in accordance with this section will be considered Covered Charges. How Covered Charges are paid is shown on the Benefit Summary. Refer to the Exclusions section for drugs, medications, and supplies that are not covered under this Plan.

The Covered Person must follow the Pre-Authorization and Other Utilization Review Provisions section and use a Participating Pharmacy or Designated Specialty Pharmacy Provider to receive the Maximum Benefits available.

Prior authorization may be required for certain Prescription Drugs before they are considered for coverage. Please call the number listed on the back of Your Identification (ID) Card or visit the Drug List website listed on Your Benefit Summary to receive information on which Prescription Drugs require prior authorization, to verify Prescription Drug coverage and pricing, or to locate a Participating Pharmacy.

After the Covered Person has paid any applicable Ancillary Charge, applicable Cost-Sharing, or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs identified on Our Drug List as eligible for benefits described in this section of the Plan. Any applicable Cost-Sharing and the Prescription Drug Class to which it applies, is shown on the Benefit Summary. Benefits are subject to all terms, conditions, limitations, and exclusions of this Plan.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section or listed on Our Drug List as a medical benefit, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. Any amount in excess of any applicable maximum amount identified under this section is not covered under any other section of this Plan.

Drug List
Only the Prescription Drugs listed on Our Drug List (sometimes known as a drug formulary) are eligible for Outpatient Prescription Drug benefits under this Policy. Drugs not on Our Drug List on the date obtained are not covered. Prescription Drugs are covered only if all active ingredients are covered under this Policy. The Drug List website is shown on Your Benefit Summary.

The inclusion of a specific Prescription Drug on the Drug List does not guarantee that a Covered Person's Health Care Practitioner will prescribe that drug for a particular medical condition, Behavioral Health or Substance Abuse disorder.

Our Drug List is reviewed at least annually and is subject to change. For example, when new drugs come to market or when a generic version of a drug comes to market, Our Drug List may be expanded or revised related to the Brand Name Drug or Generic Drug. Review Our current Drug List prior to obtaining Your Prescription Drug. Discuss cost effective treatments with Your doctor. If a Covered Person is currently taking an Outpatient Prescription Drug, We will notify You 30 days prior to any deletions, other than generic substitutions, in Our Drug List that may affect coverage for such Outpatient Prescriptions Drug.

Generic Drugs and Brand Name Drugs will be designated as "Preferred" or "Non-Preferred" on Our Drug List. The Benefit Summary may indicate different Cost-Sharing requirements based

on whether the Prescription Drug is “Preferred” or “Non-Preferred.”

Your Benefit Summary shows the required Cost-Sharing for Outpatient Prescription Drugs. Your Cost-Sharing may vary based on the tier of the Prescription Drug within Our Drug List. The tier may vary based on whether the Prescription Drug is:

1. a Generic Drug,
2. a Brand Name Drug,
3. a Prescription Maintenance Drug,
4. a Specialty Pharmaceutical,
5. a preventive drug, in accordance with the Clinical Preventive Services provision,
6. a Preferred drug; or,
7. a Non-Preferred drug.

The Drug List includes certain contraceptive Prescription Drugs and products, as identified in accordance with the Affordable Care Act. [For injectable contraceptives and contraceptive implants, see the Clinical Preventive Services provision of the Medical Benefits section.]

Please call the number listed on the back of the Your Identification (ID) Card or visit the Drug List website listed on Your Benefit Summary to receive information on which Prescription Drugs require pre-authorization, to determine whether a specific Prescription Drug is on the Drug List, or to locate a Participating Pharmacy.

Cost Difference Between Generic Drugs and Brand Name Drugs
If You obtain a Brand Name Drug when a Generic Drug or Bio-Similar Drug is available and on Our Drug List, You must pay the difference in cost between the Brand Name Drug and the Generic Drug or Bio-Similar Drug (the “Ancillary Charge”), in addition to any applicable Cost-Sharing for the Brand Name Drug.

In rare cases, there may be potential bioequivalence inconsistencies between the Brand Name Drug and its generic version. Such drug categories are: digitalis glycosides, antiepileptic drugs, antiarrhythmic agents, conjugated estrogens, esterified estrogens, warfarin anticoagulants, theophylline products, and thyroid preparations. In these cases, if Your Health Care Practitioner provides documentation that the Generic Drug is demonstrated to have lesser or adverse therapeutic effect or potential for You, We will approve the Ancillary Charge as a Covered Charge. In such cases, call Us to request a review of Your Prescription Drug.

Any applicable Ancillary Charge will not count toward satisfying any Cost-Sharing under this Plan.

Step Therapy
When alternative Prescription Drug treatments are available, We consider Covered Charges for Prescription Drugs in accordance with Our Drug List for the most cost-effective option. Before We authorize coverage of a particular Prescription Drug, We may require Your Health Care Practitioner to prescribe one or more different Prescription Drugs first, unless all such other

Prescription Drugs have been demonstrated to be clinically: 1) adverse; or, 2) non-effective for You. Requiring a particular drug or drugs to be prescribed and attempted first before authorizing a different drug is called step therapy.

Even if You have previously taken the Prescription Drug being requested, We may require step therapy under this Policy. The step therapy could include substituting the Prescription Drug with a different drug(s) or drug regimen in the same or similar therapeutic classification. Call Us to discuss options available to You.

If Your Health Care Practitioner believes a Prescription Drug that requires step therapy will result in an adverse reaction or be non-effective for You, Your Health Care Practitioner may call Cigna or complete the appropriate prior authorization form and fax it to Cigna to request a Prescription Drug List exception or prior authorization for coverage of the requested Prescription Drug(s) and related supplies. Such request must include Your Health Care Practitioner's medical support of the exception request. Your Health Care Practitioner should make this request before writing the prescription. We will make a determination on the exception request within 72 hours of the request. If We do not deny the exception request within 72 hours of Your Health Care Practitioner submitting the request, the request is considered approved.

- If the request is approved, Your Health Care Practitioner will receive confirmation to proceed with writing the prescription. The length of the authorization will depend on the diagnosis and Prescription Drugs and related supplies. Once Your Health Care Practitioner has written the prescription for the approved Prescription Drug, You should contact Your Pharmacy to fill the prescription(s).
- If the request is denied, Your Health Care Practitioner and You will be notified that coverage for the Prescription Drugs and related supplies is not authorized. If you disagree with a coverage decision, You may appeal that decision in accordance with the Grievance and Appeal Procedures document that is included with Your Certificate by submitting a written request stating why the prescription drugs and related supplies should be covered. Denial of an exception is considered an adverse determination subject to an expedited review. If Your Health Care Practitioner believes death or serious harm is probably without the requested Prescription Drug, the request is considered approved if We do not deny the request within 24 hours of the exception request.

If You have questions about a specific Prescription Drug List exception or prior authorization request, you should call Customer Service at the toll-free number on the back of your ID card.

Exception Requests
If Your Health Care Practitioner believes a Prescription Drug is excluded from coverage and that it would be clinically appropriate for Your treatment plan, Your Health Care Practitioner may call Cigna or complete the appropriate prior authorization form and fax it to Cigna to request a Prescription Drug List exception or prior authorization for coverage of the requested Prescription Drug(s) and related supplies. Such request must include Your Health Care Practitioner's medical support of the exception request. Your Health Care Practitioner should make this request before writing the prescription. An expedited exception request may be made in exigent circumstances, when a health condition seriously jeopardizes Your life, health or ability to regain maximum function. We will make a determination on the exception request within 72 hours of a standard request and 24 hours of an expedited request. If We do not deny the exception request within 72 hours of Your Health Care Practitioner submitting a standard request or 24 hours of Your Health Care Practitioner submitting an expedited request, the request is considered approved.

- If the request is approved, Your Health Care Practitioner will receive confirmation to proceed with writing the prescription. The length of the authorization will depend on the diagnosis and Prescription Drugs and related supplies. Once Your Health Care Practitioner has written the prescription for the approved Prescription Drug, You should contact Your Pharmacy to fill the prescription(s).
- If the request is denied, Your Health Care Practitioner and You will be notified that coverage for the Prescription Drugs and related supplies is not authorized. If you disagree with a coverage decision, You may appeal that decision in accordance with the Grievance and Appeal Procedures document that is included with Your Certificate by submitting a written request stating why the Prescription Drugs and related supplies should be covered. Denial of an exception is considered an adverse determination subject to an expedited review. If Your Health Care Practitioner believes death or serious harm is probable without the requested Prescription Drug, the request is considered approved if We do not deny the request within 24 hours of the exception request.

Specialty Pharmaceuticals
Covered Charges include charges for Specialty Pharmaceuticals identified on Our Drug List and dispensed by a Designated Specialty Pharmacy Provider.

A Covered Person must obtain pre-authorization from Us before a Specialty Pharmaceutical is considered for coverage, as outlined in the Pre-Authorization and Other Utilization Review Provisions section. If the Specialty Pharmaceutical is authorized, We will advise the Covered Person how the Specialty Pharmaceutical can be obtained from a Designated Specialty Pharmacy Provider, and how to file a claim with Us. Specialty Pharmaceuticals will not be covered unless they have been authorized by Us in accordance with the Pre-Authorization and Other Utilization Review Provisions and Our Specialty Pharmacy Program. Specialty Pharmaceuticals are not covered when obtained from a Pharmacy other than a Designated Specialty Pharmacy Provider.

After satisfaction of any Out-of-Pocket Limit for other Covered Charges, Coinsurance still applies to all charges for Specialty Pharmaceuticals obtained from a provider that is not a Designated Specialty Pharmacy Provider. The Drug List may indicate that certain Specialty Pharmaceuticals may be dispensed by a Designated Specialty Pharmacy Provider who is a Health Care Practitioner in an Office Visit or Outpatient setting rather than by a Designated Specialty Pharmacy Provider that is a Pharmacy. See the Benefit Summary for applicable Cost-Sharing.

For a Covered Person's first-time use of any Specialty Pharmaceutical, We may limit Our authorization to an initial 15-day treatment regimen. If the treatment regimen is continued, additional supply may be authorized.

Supply Limits
This Plan provides benefits only for the following Covered Charges for Prescription Drugs that are received on an Outpatient basis, as shown on the Benefit Summary:

1. Up to a 30 consecutive day supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging, or any limitations in this Plan. If a 90-Day Prescription Drug Provider is used, We will pay up to a 90 consecutive day supply for each Prescription Order for Prescription Maintenance Drugs covered by and through a 90-Day Prescription Drug Provider, unless restricted to

a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations, or other limitations in this Plan.

2. Up to 3 vials or up to a 30 consecutive day supply, or if a 90-Day Prescription Drug Provider is used, up to 9 vials or up to a 90 consecutive day supply, of one (1) type of self-injectable insulin, including insulin analog preparations, for each Prescription Order, whichever is less.

3. Up to 100 disposable insulin syringes and needles, up to 100 disposable visual reading strips or blood/urine/glucose/acetone testing strips that test for glucose, ketones, or protein, up to 100 lancets, or up to a 30 consecutive day supply for each Prescription Order, whichever is less. If a 90-Day Prescription Drug Provider is used, We will pay up to 300 disposable insulin syringes and needles, up to 300 disposable visual reading strips or blood/urine/glucose/acetone testing strips that test for glucose, ketones, or protein, up to 300 lancets, or up to a 90 consecutive day supply for each Prescription Order, whichever is less.

4. Prescription Maintenance Drugs that are dispensed through a 90-Day Prescription Drug Provider, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations, or other limitations in this Plan.

5. Prescription Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this Plan.

6. Prescription Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a Prescription Drug. Prescription Drugs are limited to maximum daily doses of medications that are approved by the FDA and/or supported by peer reviewed literature or sound scientific principles.

7. Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. The coverage for orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

8. Prescription Drugs treat a Covered Person's chronic, disabling, or life-threatening Sickness that is covered under this Certificate, if the Prescription Drug has been approved by the FDA for at least one indication and is recognized by either a prescription drug reference compendium approved by the commissioner of the Missouri Department of Insurance or substantially accepted peer-reviewed medical literature for treatment of the indication for which the Prescription Drug is prescribed.

Manufacturer's Packaging Limits
Some Prescription Drugs may be subject to additional supply, quantity, duration, gender, age, lifetime, Cost-Sharing, or other limits based on the manufacturer's packaging, Plan limits or the Prescription Order. Examples of these situations are:

1. If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per dispensation.

2. If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay any applicable Cost-Sharing for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product.

3. If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered, then the entire packaged and/or manufactured combination product is not covered.

Any Prescription Drug that is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, conditions, limitations, and exclusions of coverage or will not be covered by Us if the original drug would not be covered.

Payment of Benefits

Participating Pharmacy

Present Your identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable Cost-Sharing to the Participating Pharmacy, as shown on the Benefit Summary.

The following additional Cost-Sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the applicable Cost-Sharing for that Generic Drug.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the applicable Cost-Sharing for that Brand Name Drug.

3. If a Brand Name Drug is received when a Generic Drug or a Bio-Similar Drug is available, the Covered Person pays the applicable Cost-Sharing for that Brand Name Drug, plus the difference in the Maximum Allowable Amount between the cost of the Brand Name Drug and the Generic Drug or Bio-Similar Drug (referred to as the Ancillary Charge). The Ancillary Charge will not be reimbursed by Us nor does it count toward satisfying any Cost-Sharing.

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug, minus any applicable Ancillary Charge or Cost-Sharing. Any Ancillary Charge does not count toward satisfying any Cost-Sharing.

Non-Participating Pharmacy

When the Covered Person has prescriptions filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. The Covered Person will not be reimbursed.

90-Day Prescription Drug Provider

Coverage for 90-Day Prescription Orders of selected Outpatient Prescription Maintenance

Drugs may be available to You and Your Covered Dependents under this Plan.

If this service is available, We will advise You of the name and address of the 90-Day Prescription Drug Providers so that You and Your Covered Dependents can take advantage of this service. If required, order forms may be obtained from Your Policyholder or by contacting Us.

If the 90-Day Prescription Drug Provider is a Mail Service Prescription Drug Vendor and You choose home delivery of Prescription Maintenance Drugs, the Covered Person must mail the Prescription Order, a completed order form, and any required Cost-Sharing amounts to the Mail Service Prescription Drug Vendor.

The following Cost-Sharing requirements apply to covered Outpatient Prescription Maintenance Drugs that are obtained through a 90-Day Prescription Drug Provider:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the applicable 90-Day Prescription Drug Cost-Sharing for that Generic Drug.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the applicable 90-Day Prescription Drug Cost-Sharing for that Brand Name Drug.

3. If a Brand Name Drug is received when a Generic Drug or Bio-Similar Drug is available, the Covered Person pays the applicable 90-Day Prescription Drug Cost-Sharing for that Brand Name Drug, plus any applicable Ancillary Charge. Any Ancillary Charge will not be reimbursed by Us nor does it count toward satisfying any Cost-Sharing under this Plan.

4. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens, or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this Plan, We will consider benefits only for the most cost effective drug, dosage form, or packaging that would be a Covered Charge under this Plan and that will produce a professionally adequate result.

When using a Mail Service Prescription Drug Vendor, the vendor will dispense the covered Prescription Order and mail it, along with a replacement order form, to the Covered Person. It will be mailed to the Covered Person’s home or another location that is designated by the Covered Person. Some medications may have shipping restrictions.

Identification Cards
In connection with this benefit, You will receive an identification (ID) card for You and Your Covered Dependents to use while covered under this Plan.

No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this Plan. All Covered Persons are required to turn in their ID card(s) to the Policyholder at the time of coverage termination. If You fail to do so and any Covered Person uses the ID card after coverage ends, You are responsible for the entire cost of all Prescription Drugs purchased after the termination date. We will recover from You any amounts paid by Us for drugs purchased after coverage terminates under this Plan. Your

Policyholder will also be responsible for any claim payment made by Us after such termination date. You may be held liable by Your Policyholder for the amount of Prescription Drug charges that are Incurred or paid on behalf of any Covered Person after the termination date of coverage.

How To File A Claim

Participating Pharmacy

Present Your ID card each time a Prescription Order is filled at a Participating Pharmacy. Pay the Participating Pharmacy the difference between the charge for the covered Prescription Drug and the amount We will pay. This applies to each covered Prescription Drug that is filled at a Participating Pharmacy.

If the ID card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. For reimbursement of Covered Charges, the Covered Person must complete a prescription drug claim form, and send it, along with any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form. A prescription drug claim form can be obtained from Your Policyholder or Us.

Non-Participating Pharmacy

When the Covered Person has prescriptions filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. The Covered Person will not be reimbursed.

Miscellaneous Provisions

Amounts paid by Us under this section may not reflect the ultimate cost to Us for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per prescription or per refill basis, and will not be adjusted if We receive any retrospective volume drug discounts or Prescription Drug rebates under any portion of this Plan.

Manufacturer product discounts, also known as rebates, may be sent back to Us and may be related to certain drug purchases under this Plan. These amounts will be retained by Us.

Payment by Us for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section.

For the purpose of the Coordination of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate Plan and will be coordinated only with other Prescription Drug coverage. We will not provide any benefits for Prescription Drug charges that are paid by another Plan as the primary payor.

The Covered Person is responsible for any Cost-Sharing paid for each Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or due to changes in dosage, dosage regimen, or Prescription Order. These charges will not be reimbursed by Us.

EXCLUSIONS

Certificate Exclusions
We will not pay benefits for any of the following:

1. Charges that:

    a. Are not specifically listed as a Covered Charge in the Medical Benefits section or Outpatient Prescription Drug Benefits section.
    b. Are complications of a non-covered service.
    c. Are Incurred before the Covered Person's Effective Date or after the termination date of coverage, except as otherwise provided by any applicable Extension of Benefits provision.
    d. Are for any amount in excess of any Maximum Benefit for covered services.
    e. Do not meet the definition of a Covered Charge in this Plan, including, but not limited to:
        i. Charges in excess of the Maximum Allowable Amount. Additional payments negotiated by Us with providers in accordance with state and federal surprise balance billing laws are not considered in excess of the Maximum Allowable Amount.
        ii. Charges that are not Medically Necessary.
        iii. Charges Incurred for Experimental or Investigational Services, except for Routine Patient Costs in an Approved Clinical Trial.
    f. Are Incurred outside of the United States, except as otherwise covered in the Medical Benefits section.
    g. Are for Prescription Drugs obtained from Pharmacy provider sources outside the United States.
    h. Are not documented in the Health Care Practitioner's or Medical Supply Provider's records.
    i. Are related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation.
    j. Are complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Health Care Practitioner.

2. Charges that are:

    a. Payable or reimbursable by any other government law or program, except Medicaid.
    b. For free treatment provided in a federal, veteran's, state, or municipal medical facility.
    c. For free services provided in a student health center.
    d. For services that a Covered Person has no legal obligation to pay, or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.

3. Charges for particular treatment, services, supplies or drugs for which We are billed by a provider who waives or reduces the Covered Person's payment obligation of any Copayment, Coinsurance and/or Deductible amounts for such treatment, services, supplies or drugs.

4. Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability, or similar laws even when the Covered Person does not file a claim for benefits. Sickness or Injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to any of the following:

    a. The sole proprietor, if the Covered Person's employer is a proprietorship.
    b. A partner of the Covered Person's employer, if the employer is a partnership.
    c. A Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.

5. Charges for which a Covered Person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this Plan is secondary to medical payment or medical expense coverage available to the Covered Person, regardless of whether such other coverage is described as secondary or contingent.

6. Charges caused by or contributed to by:

    a. War or any act of war, whether declared or undeclared.
    b. Participation in the military service of any country or international organization, including non-military units supporting such forces.

7. Except as otherwise covered in the Medical Benefits section:

    a. Vision care that is routine.
    b. An eye exam.
    c. Glasses.
    d. Contact lenses.
    e. Vision therapy, exercise, or training.
    f. Surgery, including any complications arising therefrom, to correct visual acuity including, but not limited to: Lasik and other laser surgery, or radial keratotomy services.
    g. Surgery, including any complications arising therefrom, to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
    h. Gene therapy for vision loss.

8. Charges for gene therapy for treatment of blindness, vision loss, inherited retinal diseases or conditions, age-related macular degeneration, diabetic macular edema, corneal eye disease, or any other eye disease or disorder.

9. Charges for gene therapy services:
    a. Rendered by a Non-Participating Provider.
    b. That are not authorized by the Medical Review Manager before services are rendered.

10. Except as otherwise covered in the Medical Benefits section, charges for:

    a. Hearing care that is routine.
    b. Any artificial hearing device.
    c. Auditory prostheses or other electrical, digital, mechanical, or surgical means of

enhancing, creating, or restoring auditory comprehension.
   d. Cochlear implants.
   e. Hearing aids.

11. Charges for foot conditions including, but not limited to, expenses for:

    a. Flat foot conditions.
    b. Foot supportive devices, including orthotics and corrective shoes, except for podiatric appliances for the prevention of diabetes complications.
    c. Foot subluxation treatment.
    d. Care of corns; calluses; bunions, toenails, except for ingrown toenails; fallen arches; weak feet; chronic foot strain; or, symptomatic complaints of the feet.
    e. Hygienic foot care that is routine, except as otherwise covered in the Medical Benefits section.

12. Except as otherwise covered in the Medical Benefits section, charges for:

    a. Dental care that is routine.
    b. Dental treatment, services, or supplies.
    c. Bridges, crowns, caps, dentures, dental implants, or other dental prostheses.
    d. Dental braces or dental appliances.
    e. Extraction of teeth.
    f. Orthodontic services.
    g. Odontogenic cysts.
    h. Any other treatment, services, or supplies for complications of the teeth and gum tissue.

13. Except as otherwise covered in the Medical Benefits section, any non-surgical or non-diagnostic services or supplies provided for the treatment of temporomandibular joint and adjacent or related muscles and nerves.

14. Except as otherwise covered in the Medical Benefits section, charges for any appliance, or medical or surgical expenses for:

    a. Malocclusion.
    b. Mandibular Protrusion or Recession.
    c. Maxillary or Mandibular Hyperplasia.
    d. Maxillary or Mandibular Hypoplasia.

15. Except as otherwise covered in the Medical Benefits section, charges for any diagnosis, supplies, treatment, or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate, or regardless of potential benefits for co-morbid conditions, including, but not limited to:

    a. Weight reduction or weight control surgery, treatment, or programs.
    b. Any type of gastric bypass surgery.
    c. Suction lipectomy.
    d. Physical fitness programs, exercise equipment, or exercise therapy, including health club membership fees or services, or nutritional counseling.

16. Except as otherwise covered in the Medical Benefits section, charges for Transplant services that are:

    a. Authorized by Us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by Us.
    b. For any non-human (including animal or non FDA-approved mechanical) to human organ transplant.
    c. For the purchase price of an organ or tissue that is sold rather than donated.
    d. For travel or lodging expenses (such as hotel or meals).

17. Charges for Cosmetic Services, including but not limited to chemical peels, cosmetic treatment of varicose veins, or reconstructive or plastic surgery that does not alleviate a functional impairment, except as otherwise covered in the Medical Benefits section.

18. Charges for revision of breast surgery for capsular contraction, removal, or replacement of a prosthesis, or augmentation or reduction mammoplasty, except as otherwise covered in the Medical Benefits section.

19. Charges for prophylactic treatment, services, or surgery including, but not limited to:

    a. Prophylactic mastectomy, except for prophylactic mastectomy/hysterectomy (oophorectomy) if the Covered Person has tested positive for BRCA gene and the Covered Person meets Our medical policies for prophylactic treatment.
    b. Any other treatment, services, or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

20. Charges for: a private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse, massage therapist, or a rolfer; except as otherwise covered in the Medical Benefits section.

21. Charges for a stand-by Health Care Practitioner.

22. Charges for Custodial Care, respite care, rest care, supportive care, or homemaker services.

23. Charges for treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner, or provider.

24. Charges for services rendered by a provider who is not properly licensed or authorized in the state where services are rendered.

25. Except for covered Telehealth Services and Telemedicine Services, charges for telephone consultations, internet consultations, or e-mail consultations.

26. Charges for provider administrative expenses, including, but not limited to: expenses for claim filing, contacting utilization review organizations, or case management fees.

27. Charges for provider overhead, such as charges for supervision of caregiver(s) and caregiver training.

28. Charges for missed appointments.

29. Charges for sales tax or gross receipt tax.

30. Charges for living expenses, travel expenses, or transportation, except as otherwise covered in the Medical Benefits section.

31. Charges for growth hormone therapy, including growth hormone medication and its derivatives, or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth, except as otherwise covered in the Medical Benefits section.

32. Charges for, or related to, non-spontaneous abortion.

33. Charges for elective caesarean section.

34. Charges related to the following conditions, regardless of underlying causes:

    a. Treatment of sexual function, dysfunction, or inadequacy.
    b. Treatment to enhance, restore, or improve sexual energy, performance, or desire.

35. Charges for genetic testing or genetic counseling services, except as otherwise covered in the Medical Benefits section.

36. Charges for amniocentesis or chronic villi testing.

37. Charges for permanent sterilization, except as otherwise covered in the Clinical Preventive Services provision.

38. Charges for:

    a. Except as otherwise covered in the Medical Benefits section, infertility diagnosis and treatment, for males or females, including, but not limited to:
        i. drugs and medications, regardless of intended use.
        ii. artificial insemination.
        iii. reversal of reproductive sterilization.
        iv. treatment, and any related tests, services, or procedures, to promote conception.
    b. Cryopreservation of sperm, embryo, or eggs.
    c. Surrogate pregnancy.
    d. Umbilical cord stem cell, or other blood component, harvest and storage in the absence of a Sickness or an Injury.

39. Charges for treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person’s genetic make-up or genetic predisposition, except as otherwise covered in the Medical Benefits section.

40. Charges for chelation therapy, except for laboratory proven toxic states as defined by peer-reviewed published studies.

41. Charges to address quality of life or lifestyle concerns, and similar charges for non-functional conditions.

42. Except as otherwise covered in the Medical Benefits section, charges for:

    a. Services to address behavioral (conduct) problems.
    b. Services to build communication or social interaction or protocol skills.
    c. Services to address learning disabilities.
    d. Educational testing, training, or materials;
    e. Services to address cognitive enhancement, learning, or training.
    f. Training for activities of daily living.

43. Charges for vocational or work hardening programs, or for transitional living.

44. Charges for services provided by or through a school system.

45. Charges for:

    a. Non-medical items.
    b. Self-care or self-help programs.
    c. Aroma therapy.
    d. Massage, other than massage associated with approved Physical Therapy or chiropractic services; meditation; relaxation therapy.
    e. Naturopathic medicine
    f. Homeopathic medicine.
    g. Acupuncture, except when authorized by Us.
    h. Biofeedback, except for treatment of an Acquired Brain Injury.
    i. Neurotherapy.
    j. Electrical stimulation.
    k. Aversion Therapy.

46. Charges for treatment of hyperhidrosis (excessive sweating).

47. Charges for Inpatient treatment of chronic pain disorders, except as Medically Necessary.

48. Charges for snoring.

49. Charges for the treatment or prevention of hair loss, except as otherwise covered in the Medical Benefits section.

50. Charges for treatment, services, or supplies for a change in skin pigmentation.

51. Charges for stress management, except as otherwise covered in the Medical Benefits section.

52. Except as otherwise covered in the Medical Benefits section or Outpatient Prescription Drug Benefits section, charges for:

    a. Drugs that have not been fully approved by the FDA for marketing in the United States.

b. Drugs limited by federal law to investigational use.
c. Drugs that are used for Experimental or Investigational Services, even when a charge is made.
d. Drugs with no FDA-approved indications for use.
e. FDA-approved drugs used for indications, dosage, dosage regimens, or administration outside of FDA approval, except as otherwise covered in the Outpatient Prescription Drug Benefits section, for a chronic, disabling, or life-threatening Sickness.
f. Drugs that are undergoing a review period, not to exceed 12 months, following FDA-approval of the drug for use and release into the market.
g. Drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease, or for symptom control.

This exclusion does not apply to the Routine Patient Costs a Clinical Trial Qualified Individual Incurs while participating in an Approved Clinical Trial.

53. Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit a felony, or the Covered Person's participation in or commission of a felony, whether or not charged.

54. Charges for Prescription Drugs, medications, or other substances dispensed or administered in an Outpatient setting, except as otherwise covered in the Outpatient Prescription Drug Benefits section or the Medical Benefits section.

55. Charges for drugs and medicines prescribed for treatment of a Sickness or an Injury that is not covered under this Plan.

56. Charges for drugs, medications, or other substances that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state. This includes, but is not limited to, items dispensed by a Health Care Practitioner.

57. Charges for gene therapy drugs for vision loss; or, drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition, unless authorized by the Plan under this Outpatient Prescription Drug Benefits section before they are dispensed.

58. Charges for services ordered, directed, or performed by a Health Care Practitioner, or supplies purchased from a Medical Supply Provider, who is an Immediate Family Member or a person who ordinarily resides with a Covered Person.

    This exclusion does not apply to services ordered, directed, or performed by a Dentist.

59. Charges related to Health Care Practitioner assisted suicide.

60. Charges for venipuncture, specimen collection, and lab handling fees.

61. Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner except for:
    a. Legend prenatal vitamin Prescription Drugs when the prenatal vitamins are prescribed during pregnancy;
    b. Clinically proven vitamin deficiency syndromes that cannot be corrected by

dietary intake; or
c. Vitamins covered in accordance with the Preventive Medicine and Wellness Services provision of the Medical Benefits section.

62. Except as otherwise covered in the Medical Benefits section or the Outpatient Prescription Drugs Benefits section, charges for:

    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries, except as otherwise covered for insulin pumps in the Medical Benefits section.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements, except for amino acid-based elemental formulas and formulas to treat phenylketonuria or a heritable disease otherwise covered in the Medical Benefits section.
    g. Nutraceuticals.
    h. Tube feeding formulas and infant formulas, except for amino acid-based elemental formulas and formulas to treat phenylketonuria or a heritable disease otherwise covered in the Medical Benefits section.
    i. Medical foods.

63. Except as otherwise covered in the Medical Benefits section, charges for any over-the-counter products, drugs, or medications whether or not prescribed by a Health Care Practitioner.

64. Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.

65. Charges for: home traction units; home defibrillators; or, other medical devices designed to be used at home, except as otherwise covered in the Medical Benefits section.

66. Charges for: any injectable medications that are not specifically authorized by Us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; or, any administrative charge for drug injections.

67. Charges for:

    a. Drugs dispensed at or by a Health Care Practitioner's office, clinic, Hospital or other non-Pharmacy setting for take home by the Covered Person.
    b. Amounts above the Contracted Rate for Participating Pharmacy or Designated Specialty Pharmacy Provider reimbursement.
    c. The difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy been used.
    d. Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or insulin analog preparations, unless authorized by Us before they are dispensed.
    e. Any administrative charge for drug injections, or administrative charges for any other drugs.

68. Charges for Specialty Pharmaceuticals not on Our Drug List.

69. Charges for treatment, services, supplies, or drugs provided by or through any employer of a Covered Person, or the employer of a Covered Person's family member.

    For purposes of this exclusion, "employer" includes, but is not limited to, any corporation, partnership, sole-proprietorship, self- employment, or similar business arrangement, regardless of whether any such arrangement is a for profit or not-for-profit employer. "Employer" also includes any other affiliated providers in which there is common ownership between such providers and the "employer."

70. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity. For purposes of this exclusion, "entity" includes but is not limited to any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

71. Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including, but not limited to, the following: Participating, or instructing, or demonstrating, or guiding or accompanying others in parachute jumping, or hang-gliding, or bungee jumping, or racing any motorized or non-motorized vehicle, skiing or rodeo activities. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning, or physical preparation for any such compensated activity.

72. [Charges for contraceptive procedures, counseling, maintenance, education, drugs, and devices.]

Child Vision Services Exclusions

In addition to the exclusions listed above, the following additional exclusions apply to the Child Vision Services provision. We will not pay Child Vision Services benefits for any of the following:

1. Charges for visual therapy.

2. Charges for 2 pairs of glasses in lieu of bifocals.

3. Charges for nonprescription (Plano) lenses.

4. Charges for lost or stolen eyewear.

5. Charges for any vision treatment, service, eyewear, or supply not listed in the Child Vision Services provision.

Child Dental Services Exclusions

In addition to the exclusions listed above, the following additional exclusions apply to the Child Dental Services provision. We will not pay Child Dental Services benefits for any of the following:

1. Charges for TMJ Dysfunction arthrogram and other TMJ Dysfunction films.

2. Charges for tomographic surveys.

3. Charges for Cone Beam CT, Cone Beam multiple images 2 dimension, and Cone Beam multiple images 3 dimension.

4. Charges for viral culture.

5. Charges for saliva analysis, including chemical or biological diagnostic saliva analysis.

6. Charges for caries testing.

7. Charges for adjunctive pre-diagnostic testing.

8. Charges for:

    a. declassification procedures;
    b. special stains, either for or not for microorganisms;
    c. immunohistochemical stains; or,
    d. tissue in-situ-hybridization.

9. Charges for:

    a. electron microscopy;
    b. direct immunofluorescence;
    c. consultation on slides prepared by another provider;
    d. consultation with slide preparation; or,
    e. accession transepithelial.

10. Charges for:

    a. nutritional counseling;
    b. tobacco counseling; or,
    c. instruction on oral hygiene.

11. Charges for removal of fixed space maintainer.

12. Charges for:

    a. screw retained surgical replacement;
    b. surgical replacement with or without surgical flap;
    c. TMJ Disorder appliances and therapy;
    d. sinus augmentation with bone or bone substitutes;
    e. appliance removal; or
    f. intraoral placement of a fixation device.

13. Charges for:

    a. gold foil surfaces;
    b. provisional crown(s);
    c. post removal;

d. temporary crown(s);
e. coping;
f. endodontic implant;
g. intentional re-implantation;
h. surgical isolation of tooth;
i. canal preparation;
j. anatomical crown exposure;
k. splinting, either intracoronal or extracoronal;
l. complete interim denture, either upper or lower;
m. partial interim denture, either upper or lower;
n. precision attachment;
o. replacement precision attachment;
p. fluoride gel carrier;
q. custom abutment;
r. provisional pontic;
s. interim pontic;
t. interim retainer crown;
u. connector bar; or,
v. stress breaker.

14. Charges for orthodontic services and supplies that are not Medically Necessary.

15. Charges for Orthodontic Treatment for cosmetic purposes.

16. Charges for: repair of damaged orthodontic appliances; or, lost or missing orthodontic appliances or the replacement thereof.

17. Charges for equilibration, periodontal splinting, full mouth rehabilitation, restoration for misalignment of teeth, or other orthodontic services that restore or maintain the occlusion or alter vertical dimension.

18. Charges for any other Dental or Orthodontic Treatment, service, or supply not listed in the Child Dental Services provision.

Outpatient Prescription Drug Benefits Exclusions

In addition to the exclusions listed above that are applicable to the Medical Benefits section, the following additional exclusions apply to the Outpatient Prescription Drug Benefits section. We will not pay benefits for any of the following:

1. Charges for drugs not on Our Drug List.

2. Charges for drugs from a Non-Participating Pharmacy.

3. Charges for that part of any Prescription Order exceeding a 30 consecutive day supply per Prescription Order. Charges for that part of any Prescription Order exceeding a 90 consecutive day supply if the Prescription Drug is dispensed through a 90-Day Prescription Drug Provider.

4. Charges for drugs that are paid under another Plan or another payor as primary payor.

5. Charges for any Ancillary Charge.

6. Charges in excess of the Maximum Allowable Amount for any Prescription Drug.

7. Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or insulin analog preparations, unless pre-authorized by Us before they are dispensed.

8. Charges for any injectable Prescription Drugs or Specialty Pharmaceuticals, unless pre-authorized by Us before they are dispensed.

9. Charges for Specialty Pharmaceuticals from a Pharmacy provider other than a Designated Specialty Pharmacy Provider.

10. Any administrative charge for drug injections or administrative charges for any other drugs.

11. Charges for devices or supplies including, but not limited to: blood/urine/glucose/acetone testing devices, needles and syringes, lancets, test strips for use with a glucose monitor, support garments, bandages, and other non-medical items regardless of intended use, except as described under a Prescription Order.

12. Charges for over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except for injectable insulin, insulin analog preparations, and medications for controlling blood sugar level that are otherwise covered under the Medical Benefits section; or, drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us, unless specifically authorized for coverage by Us on Our Drug List.

13. Charges for allergy sera or allergy extract.

14. Charges for: bulk powder/chemical drugs; drugs containing or made of bulk powder/chemicals; Compounded Medications that contain one (1) or more active ingredients that are not covered under this Plan; combination drugs or drug products manufactured and/or packaged together and containing one (1) or more active ingredients that are not covered under this Plan; or, combination drugs or drug products that are manufactured and/or packaged together, unless pre-authorized by Us before they are dispensed.

15. Charges for: Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order; amounts in excess of the Generic Drug prescription cost; amounts in excess of the Reference Price for a Prescription Drug or Prescription Drug Class; or, amounts above the Contracted Rate for Participating Pharmacy or Designated Specialty Pharmacy Provider reimbursement.

16. Charges for: drugs administered or dispensed by a Hospital, rest home, sanitarium, extended care facility, convalescent care facility, Subacute Rehabilitation Facility, or similar institution; drugs consumed, injected, or otherwise administered at the prescribing Health Care Practitioner's office; or, drugs that are dispensed at or by a Health Care Practitioner's office, clinic, Hospital, or other non-Pharmacy setting for take

home by the Covered Person.

17. Charges for: any drug used for Cosmetic Services, as determined by Us; drugs used to treat onychomycosis (nail fungus); or, botulinum toxin and its derivatives.

18. Charges for: drugs taken solely to prevent the transmission of disease during activities such as intercourse, sharing of needles, or direct or indirect exchange of bodily fluids, except as otherwise covered in the Clinical Preventive Services provision.

19. Charges for: drugs prescribed for dental services except when covered under the Child Dental Services provision, or unit-dose drugs.

20. Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne or related conditions for a Covered Person age 30 or older.

21. Charges for: duplicate prescriptions; replacement of lost, stolen, destroyed, spilled, or damaged prescriptions; or, prescriptions refilled more frequently than the prescribed dosage indicates.

22. Charges for drugs used to treat, impact, or influence quality of life or lifestyle concerns, including, but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; or, prevention or treatment of excessive hair growth or abnormal hair patterns. For purposes of this exclusion, anabolic steroids will not be subject to this exclusion if they are determined by Us to be Medically Necessary.

23. Charges for drugs used to treat, impact, or influence: obesity; morbid obesity; weight management; sexual function, dysfunction, or inadequacy; sexual energy, performance, or desire; skin coloring or pigmentation; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

24. Charges for drugs or drug categories that exceed any Maximum Benefit limit under this Plan.

25. Charges for prescriptions, dosages, or dosage forms used for the convenience of the Covered Person or the Covered Person’s Immediate Family Member or Health Care Practitioner.

26. Charges for drugs obtained from Pharmacy provider sources outside the United States, except for Covered Charges that are received for Emergency Treatment.

27. Charges for: postage, handling, or shipping charges for any drugs.

28. Charges for: vaccines and other immunizing agents, except as otherwise covered in the Medical Benefits section; or biological sera, blood, or blood products.

29. Charges for drugs for which prior authorization is required by Us and is not obtained.

30. Charges for treatment, services, supplies, or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person’s family member. For purposes of this exclusion, "employer" includes, but is not limited to: any corporation,

partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer. "Employer" also includes any other affiliated providers in which there is common ownership between such providers and the “employer.”

31. Charges for treatment, services, supplies, or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to, an ownership interest in any such entity. For purposes of this exclusion, "entity" includes, but is not limited to: any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

32. [Charges for contraceptive drugs and devices; oral contraceptives.]

COORDINATION OF BENEFITS (COB)

Coordination of this Certificate's Benefits with Other Benefits
This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Coordinating Plan. Coordinating Plan is defined below.

The order of benefit determination rules govern the order in which each Coordinating Plan will pay a claim for benefits. The Coordinating 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 Coordinating 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 Coordinating Plans equal to 100% of the total Allowable Expense.

Definitions for COB

Coordinating Plan
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.

(1) Coordinating Plan includes: group and nongroup subscriber contracts, health maintenance organization (HMO) contracts; Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Coordinating Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. is a separate Coordinating Plan. If a Coordinating Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coordinating Plan.

This Plan
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 Coordinating 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 other separate COB provisions to coordinate other benefits.

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 Coordinating Plan.

When This Plan is primary, it determines payment for its benefits first before those of

any other Coordinating Plan without considering any other Coordinating Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Coordinating Plan and may reduce the benefits so that all Coordinating Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense
A health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Coordinating Plan covering the person. When a Coordinating 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 Coordinating Plan covering the person is not an Allowable Expense. In addition, any expense that a health care provider or physician by law or in accord 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:

1. 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 Coordinating Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Coordinating Plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, 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.

3. If a person is covered by two or more Coordinating Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Coordinating Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Coordinating Plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the Allowable Expense for all Coordinating Plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Coordinating Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

Allowed Amount
The amount of a billed charge that a carrier determines to be covered for services

provided by a non-participating health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

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

Custodial Parent
The parent awarded custody by a court order or, in the absence of a court order, is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Coordinating Plan.

(b) 1. Except as provided in (c), a Coordinating Plan that does not contain a COB provision that is consistent with state law is always primary unless the provisions of both Coordinating Plans state that the complying plan is primary.

2. 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 must be excess to any other parts of the Coordinating 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.

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

(d) If the primary plan is a Closed Panel Plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(e) When multiple contracts providing coordinated coverage are treated as a single Coordinating Plan under this subchapter, this section applies only to the Coordinating Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Coordinating Plan, the carrier designated as primary within the Coordinating Plan must be responsible for compliance with this COB provision.

(f) If a person is covered by more than one secondary plan, the order of benefit determination

rules of this COB provision decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other Coordinating Plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(g) Each Coordinating Plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The Coordinating 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 Coordinating 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 Coordinating 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 Coordinating Plans is reversed so that the Coordinating Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Coordinating Plan is the primary plan.

(2) Dependent Child Covered Under More Than One Coordinating Plan. Unless there is a court order stating otherwise, when a dependent child is covered by more than one Coordinating Plan the order of benefits is determined as follows:

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(i) The Coordinating Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
(ii) If both parents have the same birthday, the Coordinating Plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Coordinating Plan of that parent has actual knowledge of those terms, that Coordinating Plan is primary. This rule applies to plan years commencing after the Coordinating Plan is given notice of the court order.
(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
(iii) if a court order 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 (h)(2)(A) must determine the order of benefits.
(iv) if there is no court order 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 Coordinating Plan covering the custodial parent;
(II) the Coordinating Plan covering the spouse of the custodial parent;
(III) the Coordinating Plan covering the noncustodial parent; then

(IV)the Coordinating Plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one Coordinating Plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) a dependent child who has coverage under either or both parents' Coordinating Plans and has his or her own coverage as a dependent under a spouse's Coordinating Plan, (h)(5) applies.

In the event the dependent child's coverage under the spouse's Coordinating Plan began on the same date as the dependent child's coverage under either or both parents' Coordinating Plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The Coordinating 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 Coordinating 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 Coordinating Plan does not have this rule, and as a result, the Coordinating Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) 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 Coordinating Plan, the Coordinating 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, state, or other federal continuation coverage is the secondary plan. If the other Coordinating Plan does not have this rule, and as a result, the Coordinating Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

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

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of Coordinating Plan. This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coordinating Plans 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 Coordinating 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 Coordinating Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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 must not apply between that Coordinating Plan and other Closed Panel Plans.

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 Coordinating Plans. We will comply with federal and state law concerning confidential information. We may get the facts we need 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 Coordinating Plans covering the person claiming benefits. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits.

Facility of Payment
A payment made under another Coordinating Plan may include an amount that should have been paid under This Plan. If it does, We 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. We 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.

Right of Recovery
If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have 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.

Medicare as Secondary Plan
Under federal law, Medicare is often the secondary plan for COB purposes if a Covered Person has other coverage in addition to Medicare.

The rules require benefits be paid under other coverage before Medicare when:

You and/or Your Covered Dependent spouse are age 65 or older, and Your Employer employs at least 20 persons (including part-time Employees) for a minimum of 20 weeks during the current or preceding Calendar Year.

You and/or Your Covered Dependent are age 65 or older and are receiving Medicare benefits due to a disability, and Your Employer has at least 100 people actively employed on 50 percent or more of the regular business days in the preceding Calendar Year.

A Covered Person is covered under an employer group health plan, is age 64 or younger, and is eligible for Medicare due to end-stage renal disease. In this case, Medicare is usually secondary to coverage under This Plan for 30 months from the date of Medicare eligibility.

CLAIM PROVISIONS

Notice of Claim
We do not require a separate notice of claim. See the Claim Forms and Proof of Loss provisions below for the claim submission process.

Claim Forms
We will furnish to the person making a claim, or to the Policyholder for delivery to a person making a claim, the forms usually provided by Us for filing a proof of loss.

If the forms for a proof of loss are not provided before the 16th day after the date We received notice of a claim under the Policy, the person making the claim is considered to have complied with the proof of loss requirements upon submitting, within the time set in this Plan for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

Proof of Loss
Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received due to a condition, preventive service, Sickness or Injury for which the claim is made. Written proof of the loss must be provided to Us no later than the 180th day after the date of the loss. Failure to provide written proof of a loss within that time does not reduce or invalidate a claim if:

1. It was not reasonably possible to provide written proof of the loss within that time;

2. Written proof of the loss is provided as soon as reasonably possible; and

3. Unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required.

The proof of loss must include all of the following:

1. Your name, and Certificate number and group number.

2. The name of the Covered Person who Incurred the claim.

3. The name and address of the provider of the services.

4. An itemized bill from the provider of the services that includes all of the following as appropriate:

    a. International Classification of Diseases (ICD) diagnosis codes.
    b. International Classification of Diseases (ICD) procedures.
    c. Current Procedural Terminology (CPT) codes.
    d. Healthcare Common Procedure Coding System (HCPCS) level II codes.
    e. National Drug Codes (NDC).
    f. Current Dental Terminology (CDT) codes.

5. A statement indicating whether the Covered Person has coverage for the services under any other insurance plan or program. If the Covered Person has other coverage, include the name and Certificate or policy number of the other coverage.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

Right to Collect Information
To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within 45 days of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.

2. Provide Us with information We requested about pending claims, other insurance coverage, or proof of Creditable Coverage.

3. Provide Us with proof that the facility or provider meets the qualification and accreditation requirements under this Plan.

4. Provide Us with information as required by any contract with Us or a network, including, but not limited to, repricing information.

5. Provide Us with information that is accurate and complete.

6. Have any examination completed as requested by Us.

7. Provide reasonable cooperation to any requests made by Us.

If We request an attachment or other information from a person other than the Participating Provider who submitted the claim, charges will not be denied.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

If We need additional information from a treating Participating Provider to determine Our liability, We will make a request, within timeframes required by state law, only the relevant and necessary for clarification of the claim.

Physical Examination
As often as may be reasonably required while a claim is pending, we have the right to have a Health Care Practitioner of Our choice examine a Covered Person regarding a claim for benefits or when authorization is requested under the Pre-Authorization and Other Utilization Review Provisions section. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.

Payment of Benefits
When We receive due written proof of loss, benefits for services provided by a Non-Participating Provider will be paid to the Covered Person unless they have been assigned to a Health Care Practitioner, facility or other provider. We pay Participating Providers directly for Covered Charges. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate, or the providers of the services. In accordance with the Consolidated Appropriations Act (CAA), we will make payment of benefits immediately after receiving proof of loss, but no later than 30 days for claims submitted for the following services:

- Emergency services;
- Air ambulance services; and
- Non-emergency services provided by a Non-Participating Provider during a visit at a Participating Provider facility.

We will pay medical and dental claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual, Current Dental Terminology (CDT), or International Classification of Diseases (ICD) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Submitted charges may be applied to the Covered Person's Deductible without review. Application of the charges to the Deductible does not guarantee future coverage of similar expenses. We reserve the right to review all claims for eligibility for coverage at the time each claim is submitted. You may request a review while claims are being applied to the Deductible by calling Our Home Office or writing to Us.

Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

Payment of Benefits in Compliance with the Consolidated Appropriations Act (CAA)
Benefits will be paid for Covered Charges in compliance with the CAA (which includes the No Surprises Act). For additional information please see the Payment of Non-Participating Provider and Non-Participating Pharmacy Benefits provision within the Provider Charges and Maximum Allowable Amount Provisions section as well as the Emergency and Ambulance Services benefits under the Medical Benefits section of this Certificate.

Payment of Benefits for Terminated Persons
If a benefit is paid for a Covered Person and We are later notified that coverage for that person was terminated before the Covered Charges were Incurred, We have the right to bill the Policyholder. The bill will be for the claim amount minus the premium paid from the date coverage terminated, to the date We are notified of the termination by the Policyholder.

Rights of Administration
We maintain Our ability to determine Our rights and obligations under this Plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Misrepresentation
Claims will be denied in whole or in part in the event of intentional misrepresentation of a

material fact or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this Plan and it is later shown the claims for these benefits involved fraud or intentional misrepresentation of a material fact, We will be entitled to a refund from You, the beneficiary or the person receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

GRIEVANCE AND APPEAL PROCEDURES

APPEALS OF CLAIMS PAYMENT DECISIONS

For the purposes of this section, any reference to "You", "Your", or "Covered Person" also refers to a representative or Health Care Practitioner designated by You to act on Your behalf, unless otherwise noted.

Definitions

Grievance means a written complaint submitted by or on behalf of a Covered Person regarding:

- Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- Claims payment, handling, or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and a health carrier.

Adverse Determination means a determination by Us or Our designee utilization review entity that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to a Covered Person has been reviewed and, based on information provided, does not meet Our or Our utilization review entity's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or are Experimental or Investigational, and the payment for the requested services is therefore denied, reduced or terminated.

There are two levels of appeal for coverage decisions, First Level Appeal and Second Level Appeal, which are described in the next provision. To initiate a first level appeal, You must submit a request for an appeal in writing. We will acknowledge receipt of Your appeal or grievance within 10 business days. You should state the reason why You feel Your appeal or grievance should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call the number for Claims or Customer Service as shown on Your identification card or write to Us at the address below:

[Allied Benefit Systems, LLC
Attention: Appeals Department
200 West Adams Street, Suite 500
Chicago, IL 60606]

INTERNAL APPEAL REVIEW

If You are not satisfied with an administrative, eligibility, rescission of coverage, denial or reduction of benefit or a health care determination for pre-service, or current care coverage determination decision, You or Your appointed representative have the right to file an appeal or a grievance, verbally or in writing, no later than 180 days from the date of notification of initial denial or notification of first level resolution, as applicable.

Your appeal will be reviewed and the decision will be made by someone not involved in the initial decision. Appeals involving Medical Necessity, clinical appropriateness, or Experimental and Investigational will be considered by a health care professional.

We will respond in writing with a decision within 20 working days after We receive an appeal for a required pre-service or concurrent care coverage determination (decision), a post-service coverage determination, or other grievance. If the investigation cannot be completed within 20

working days after receipt of a grievance, You will be notified in writing on or before the 20th working day with the specific reasons why additional time is needed, and the investigation will be completed within 30 working days after that time.

We will notify You or the person who submitted the grievance of the grievance's resolution within 15 working days after the investigation is completed, If the determination is upheld, You will have the right to file an appeal for a second level review. Within 5 working days after the investigation is completed, someone not involved in the initial decision will decide upon the appropriate resolution of the grievance and notify You in clear and specific written terms of Our decision regarding the grievance and of Your right to file an appeal for a second level review. Your second level appeal will be reviewed and the decision will be made by a grievance panel consisting of other Insureds and Our representatives not involved in the initial determination or first level appeal decision. Review by the grievance advisory panel will follow the same time frames as a first level review, except as provided for in the written procedures of expedited review, if applicable. Any decision of the grievance advisory panel will include notice of the Covered Person or the plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice will contain the toll-free telephone number and address of the director's office.

If the grievance panel upholds the decision involving an Adverse Benefit determination, the panel's decision will be reviewed by two independent clinical peers in the same or similar specialty that would typically manage the case under review.

- If both independent reviews concur with the panel's decision, the decision is upheld;
- If both independent reviews disagree with the panel's decision, the initial Adverse Determination is overturned;
- If one independent review disagrees with the panel's decision, the panel will reconvene and make a final decision.

The review of a second level appeal by the grievance panel must be completed and its decision provided to You in writing within 25 calendar days after receipt of the second level appeal.

If the second level review upholds the first level appeal decision or Adverse Determination, We will deem the internal appeals process to be exhausted and You may request an external review, if applicable. External review is only available for Adverse Determinations. We or Our designee utilization review agent will send You, with the final Adverse Determination, the information for requesting an external review.

You may request that the internal appeal process be expedited if:

1. The timeframes under this process would seriously jeopardize Your life, health, ability to regain maximum function, or in the opinion of Your Health Care Practitioner, would cause You severe pain which cannot be managed without the requested services;
2. Your appeal involves non-authorization of an admission or continuing inpatient stay; or
3. You are appealing an adverse determination.

A medical review agent that has not previously reviewed the case and is of similar specialty to the treating Health Care Practitioner will decide, in consultation with the treating Health Care Practitioner, if an expedited review is necessary. When an appeal is expedited, We will respond orally within 72 hours from the date all information necessary to complete the appeal is received and will provide written confirmation of Our decision covering an expedited review within 3 working days of providing notification of the determination.

You may file an external review for an adverse determination with the Missouri Department of Commerce and Insurance (DCI) prior to exhausting all levels of the internal appeal review process.

RIGHT TO EXTERNAL REVIEW
If You are not satisfied with an Adverse Determination decision of the internal appeal review process regarding Your Medical Necessity, clinical appropriateness, health care setting, level of care, effectiveness of a covered benefit, whether a treatment is an Experimental or Investigational issue, or any other matter that involves medical judgment, You have the right to an external review. You may also request an external review for Rescission of coverage. The external review process allows for an independent outside review of an Adverse Determination by health plans.

Adverse Determination decisions mean the plan decided against Your request to authorize care or refuse to pay for services already performed. A decision to use the external level of appeal will not affect Your rights to any other benefits under the plan.

There is no charge for You to initiate the external review process. We will abide by the decision of the state.

Standard External Review
You may submit a standard external review request by contacting the Missouri Department of Commerce and Insurance (DCI) for an external review after the date You received an Adverse Determination notice.

Provide all necessary paperwork and information to the DCI, as provided in the Adverse Determination, first level appeal decision, or second level appeal decision notification.

Expedited External Review
In some cases, You may ask for an expedited (faster than usual) external review. An expedited review may be requested when you receive an adverse determination and:

1. The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

OR

2. The timeframe to do a standard external review would place Your life, health or ability to regain maximum function in danger.

To request an external review, You must contact the Missouri Department of Commerce & Insurance (DCI). For information on how to file your complaint, visit the DCI website at [https://insurance.mo.gov/consumers/health/externalreviewprocess.php] or call the Insurance Consumer Hotline at [800-726-7390] on weekdays from 8:00 A.M. to 5:00 P.M.

For a life-threatening condition, the independent review organization will provide its decision within 72 hours after the organization receives the information necessary to make the determination. If the DCI cannot resolve a grievance, the appeal will be referred to an independent review organization for review.

For a condition other than life-threatening condition the independent review organization will provide its decision to the DCI within 20 days after the date the organization receives the information necessary to make the determination and the DCI will notify You of the decision as soon as possible. The entire external review process should not take longer than 45 days from the date the organization receives all necessary information for conducting the review.

Missouri Department of Commerce and Insurance
You have the right to contact the Director of the Missouri Department of Commerce and Insurance at any time for assistance by mail at [P.O. Box 690, Jefferson City, Missouri 65101]; or by phone at [(800) 726-7390] or [(573) 751-2640].

RECOVERY PROVISIONS

Overpayment
If a benefit is paid under this Plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You, the beneficiary or the provider of the medical treatment, services or supplies. We may offset the overpayment against future benefit payments. We may not request a refund or an offset against a claim more than 12 months after We have paid a claim except in cases of fraud or misrepresentation by the Health Care Practitioner.

Right to Reimbursement
If benefits are paid under this Certificate, and any Covered Person recovers against any person or organization by settlement, judgment or otherwise, We have a right to recover from that Covered Person an amount equal to the amount We have paid.

A Covered Person's recovery is an amount that is equal to the less of:

1. If not represented by an attorney:

    a. One-half of the Covered Person's gross recovery; or
    b. The total cost of benefits paid, provided, or assumed by the payor as direct result of the tortious conduct of the third party.

2. If represented by an attorney:

    a. One-half of the Covered Person's gross recovery less attorney's fees and procurement costs; or
    b. The total costs of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs.

We may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the Covered Person or the Covered Person's Immediate Family did not pay the premiums for coverage.

Any payments We make prior to a determination of a work-related Injury will be reimbursed when a Covered Person receives payment for such Injury from another source.

Workers' Compensation Not Affected
Insurance under this Plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

CERTIFICATE HOLDER EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Certificate Holder
An eligible person may elect to be covered under this Plan by completing and signing an enrollment form that is approved by Us. The date coverage begins depends upon the date on which the Policyholder's Plan first becomes effective for the enrollment of Employees and the date a person first enrolls for coverage.

You will be covered under this Plan on the latest of the following dates:

1. On the date the Policyholder's Plan first becomes effective with Us provided that You:

    a. Are eligible for coverage on that date; and
    b. Are employed on a Full-Time Basis by the Policyholder; and
    c. Have satisfied any Employment Waiting Period; and
    d. Enroll for coverage during the initial enrollment period.

2. On the date You first become eligible for coverage provided that You:

    a. Are Currently Performing Services for the Policyholder; and
    b. Have satisfied any Employment Waiting Period; and
    c. Enroll for coverage on or before the date You first become eligible for coverage.

3. On the first day of the calendar month following the date You enroll for coverage provided that You:

    a. Are Currently Performing Services for the Policyholder; and
    b. Have satisfied any Employment Waiting Period, if applicable; and
    c. Enroll for coverage within 31 days after You first become eligible for coverage.

4. On the date provided in accordance with a Special Enrollment Period.

5. On the date We approve Your enrollment for coverage with Us as a Late Entrant.

If You are an Employee of more than one Policyholder that has a group health plan with Us, You will be considered an Employee of only one of those Policyholders for the purpose of obtaining insurance coverage.

The Certificate Holder's coverage will be governed by the laws of the state where the Policy is delivered.

Effective Date of Change in Coverage for Certificate Holders and Dependents
If You decide to add or modify coverage for Yourself or any Covered Dependents the addition or modification of this coverage may require You or any Covered Dependents to provide evidence of eligibility, and the Effective Date would then be the date that it is approved by Us.

Certificate Holder's Termination Date
Your insurance and all benefits will terminate at 12:01 a.m. local time at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates.

2. The last day of the period for which a required premium contribution was paid to Us, if the next required premium is not paid, subject to the Grace Period provision.

3. The date there is an act or practice that constitutes fraud, or an intentional misrepresentation of a material fact made by or with the knowledge of any Covered Person with regard to eligibility for this coverage or filing a claim for benefits in connection with this coverage.

4. The first day of the premium month that coincides with, or next follows, the date You are no longer employed by the Policyholder, or treated or considered an Employee by the Policyholder. The Policyholder must notify Us in writing within 30 days of the date You are no longer employed by the Policyholder, or treated or considered an Employee by the Policyholder.

5. The first day of the premium month that coincides with, or next follows, the date You are no longer Currently Performing Services on a Full-Time Basis for a period of 3 months. The Policyholder must notify Us in writing within 30 days of the date You are no longer Currently Performing Services on a Full-Time Basis for a period of 3 months.

6. The first day of the premium month that coincides with, or next follows, the date You stop Currently Performing Services for the Policyholder, including layoff, retirement or leave of absence (other than a leave of absence You are entitled to under the federal Family and Medical Leave Act). The Policyholder must notify Us in writing within 30 days of the date You stop Currently Performing Services.

7. The first day of the premium month that coincides with, or next follows, the date You become a temporary, seasonal, or part-time Employee of the Policyholder. The Policyholder must notify Us in writing within 30 days of the date You become a temporary, seasonal, or part-time Employee of the Policyholder.

8. The date of the Certificate Holder's death. We will refund any unearned premium.

Termination Date of Coverage under the Policy
We are required to renew, or continue in force, the coverage at the option of the Policyholder. We may only terminate, non-renew, or discontinue coverage in accordance with applicable state or federal law. We may not terminate the Policy prior to the first anniversary date of the effective date of the Policy. Notice of any intention to terminate will be given to the Policyholder at least 31 days prior to the effective date of termination.

The Policyholder's insurance under the Policy will terminate in accordance with the Effective Date and Termination Date section in the Policy.

Extension of Benefits for Medical Coverage Only for Total Disability
If a Covered Person is Totally Disabled on the date this coverage terminates, We may extend benefits only for Covered Charges Incurred to treat the Sickness or Injury that directly caused the Total Disability if the Sickness commenced or the Injury was sustained while this Plan was in force. Benefits are subject to all the terms, conditions, limitations, and exclusions in this Plan. Premium payment will not be required during the extension of benefits period. Medical documentation verifying Total Disability must be sent to Us within 60 days after termination.

The extension will end on the earliest of:

1. The date on which services are no longer required to treat the Sickness or Injury that caused the Total Disability.

2. The date the Covered Person is no longer Totally Disabled.

3. 90 days from the date coverage would have terminated under this Plan if there were no extension of benefits.

4. The date the Covered Person is eligible for medical coverage that provides substantially equal level of benefits when this coverage is being discontinued and replaced.

5. The earliest date otherwise permitted by law.

DEPENDENT EFFECTIVE DATE AND TERMINATION DATE

Eligibility of Dependent
If Dependents are eligible for enrollment under this Plan, then Your Dependent is eligible for insurance under this Plan on the latest of the following dates:

1. The date insurance coverage for Dependents is available under the Policyholder's Policy.

2. The date You become eligible for insurance under this Plan.

3. The date on which a person meets the definition of a Dependent.

4. The date provided in accordance with a Special Enrollment Period.

Effective Date of Dependent
A Dependent cannot be covered under this Plan until You are covered under this Plan. To obtain coverage for Your Dependents, You must apply for Dependent coverage under this Plan on forms provided by Us. You must submit any health or other information required by Us. If approved by Us, coverage for Your Dependents will take effect at 12:01 a.m. local time at the main office of the Policyholder on the first day of the calendar month that coincides with or next follows:

1. The Eligibility Date, if You apply for Dependent coverage on or before Your Effective Date and the Dependent is included on Your initial enrollment form for coverage under this Plan; or

2. The date of enrollment, if You apply for Dependent coverage within 31 days after the Dependent first becomes eligible for coverage under Your Plan; or

3. The date determined by Us, if the Dependent is a Late Entrant.

You must provide Us with written notification and an enrollment form for any change in Dependent status within 31 days of the change.

Adding a Newborn Child
Coverage for a newborn Dependent child will take effect at birth. You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 31 days of birth. Coverage includes Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities

If written notification and the required premium are not received within the first 31 days from the child's birth, the child will only be covered for the first 31 days from birth.

An enrollment form is required in order to continue coverage beyond the thirty-one-day period after the date of birth. You must notify Us of the birth, either orally or in writing, and upon notification, We will provide You with all forms and instructions necessary to enroll the newly born child. We will allow You an additional ten days from the date the enrollment form and instructions are provided in which to enroll the newly born child.

Adding an Adopted Child
Coverage for a newly adopted Dependent child will take effect on the date the adoption becomes final, the date the Policyholder becomes a party in a suit for adoption of the child, or at birth if a petition for adoption is filed within 30 days of child's birth and will include the necessary care and treatment of medical conditions existing prior to the date of placement. You must call Our office or send Us notice of the adoption, or suit for adoption, of the child and We must receive any required additional premium within 31 days of the adoption, placement, or suit for adoption. If written notification and the required premium are not received within the first 31 days from the date the Policyholder became a party in a suit for adoption of the child or the adoption was final, the child will only be covered for the first 31 days from such date.

Adding a Child for Whom a Court Order Requires You to Provide Health Insurance
A child for whom a court order requires You or Your Covered Dependent spouse to provide health insurance will be covered if We receive satisfactory written evidence of the medical support order or notice of a medical support order. Any required premium must be received by Us within 31 days from Our notice or receipt of the medical support order.

If these requirements are not met, the child will be covered for the first 31 days from the date of the court order.

Termination Date of Covered Dependent
Insurance and all benefits for a Covered Dependent will terminate at 12:01 a.m. local time at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates; or

2. The date We receive Your written request or a later date that is requested for termination of a Covered Dependent; or

3. The date this Plan terminates; or

4. The date the Policyholder's Policy is changed to no longer allow Dependent coverage under this Plan; or

5. The last day of the period for which a required premium contribution was paid to Us, if the next required premium is not paid, subject to the Grace Period provision in the Policy; or

6. The date a Covered Dependent no longer meets the Dependent definition in this Plan; or

7. For Your spouse's coverage only, the date You and Your spouse are legally divorced; or

8. The date the Covered Dependent becomes eligible for Medicare, if allowed by federal law.

CONTINUATION

If You or any Covered Dependents have been continuously insured for at least 3 consecutive months and are no longer eligible for coverage under this Plan, coverage may be continued. You and any Covered Dependents are not eligible for continuation if Your coverage under this Plan terminated due to involuntary termination of Your employment for cause. Your Policyholder will inform You of the right of continuation.

Notification Requirements
A person eligible for federal or state continuation under this section must notify the Policyholder, in writing, of:

1. the employee's death or retirement;

2. a legal divorce or legal separation; or

3. the loss of a minor child's eligibility as a Dependent, as defined in the Eligibility of Dependent provision.

Such notice must be given to the Policyholder within 60 days of the later of:

1. the date of the event; or,

2. the date the qualified beneficiary would lose coverage.

Election to Continue Coverage
To continue coverage, written notice of the election to continue coverage for You or Your Covered Dependents must be provided to Your Policyholder. A minor child's parent or legal guardian may elect continuation coverage on behalf of a Covered Dependent child.

The first required premium must accompany such notice. Thereafter, the required premium must be paid to Your Policyholder in advance of each premium due date and in accordance with Your Policyholder's instructions.

Your notice of the election to continue coverage must be provided to the Policyholder in writing within 60 days following the later of:

1. the date coverage would otherwise terminate; or

2. the date You were given notice of the right to continue coverage by the Policyholder.

Coverage remains in effect during the 60-day notification period, provided that premium is paid.

The Policyholder must provide notification to Us of the coverage continuation elected for You and any Covered Dependents.

State Continuation Rights
Missouri law provides for state continuation coverage applicable to any Policyholder maintaining a group health insurance plan and employing less than 20 full-time equivalent employees on more than 50% of its typical business days during the previous Calendar Year that is otherwise identical to coverage under Federal COBRA. For additional information on definitions, eligibility,

coverage duration and other applicable rights and provisions refer to the following section, Federal COBRA Continuation Rights.

Federal COBRA Continuation Rights
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as enacted, and later amended, contains federal requirements for continuation coverage.

Minimum Group Size
COBRA legislation applies to any Policyholder, except the federal government and religious organizations, who:

1. Maintains a group health insurance plan; and

2. Employed 20 or more full-time equivalent employees on more than 50% of its typical business days during the previous Calendar Year.

For the purpose of the Federal COBRA Continuation Rights provision, employee means persons who are part-time, full-time, owners or partners of the Policyholder.

Covered Persons will not be eligible for federal COBRA continuation if the Policyholder is exempt from the provisions of COBRA; however, continuation may be available under the State Continuation Rights provision.

Definitions
- *Group Health Insurance Plan:* For the purpose of this Federal COBRA Continuation Rights provision, group health insurance plan means any medical, dental, vision care and Prescription Drug coverage that is included in the Policy.

- *Qualified Beneficiary:* For the purpose of this Federal COBRA Continuation Rights provision, qualified beneficiary means any person who, on the day before any event that would qualify him or her for continuation under this section, is covered under this Plan, including a minor child born to, or placed for adoption with, the Certificate Holder during a continuation period.

Loss of Coverage
In general, if group health insurance coverage for a qualified beneficiary ends due to termination of employment (unless employment is terminated due to gross misconduct) or reduction of work hours, the qualified beneficiary may elect to continue benefits for up to 18 months from the date coverage would otherwise end.

If the Certificate Holder dies while covered, any qualified beneficiary whose group health insurance coverage would otherwise end may elect to continue such benefits for up to 36 months.

Upon legal divorce or legal separation, any qualified beneficiary whose group health insurance coverage would otherwise end may elect to continue such benefits for up to 36 months.

In general, if a Covered Dependent child’s group health insurance coverage ends due to loss of Dependent eligibility, such qualified beneficiary may elect to continue such benefits up to 36 months.

Concurrent Continuations
If a Covered Dependent elects to continue his or her group health insurance coverage due to Your termination of employment or reduction of work hours, the qualified beneficiary may elect to extend their 18 month, or 29 month, continuation period for up to an additional 36 months, if, during the initial 18 month or 29 month continuation period, either:

1. the Covered Dependent becomes eligible for 36 months of group health insurance coverage due to any of the reasons stated above; or

2. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will run concurrently.

Disabled Qualified Beneficiaries
In general, if a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health insurance coverage would otherwise end due to termination of employment or reduction of work hours, the qualified beneficiary may elect to extend the 18 month continuation period for up to an additional 11 months.

To elect the 11 month extension of continuation, a qualified beneficiary must give the Policyholder written proof of the Social Security's determination of the disability before the earlier of:

1. the end of the initial 18 month continuation period; or

2. 60 days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month extended continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify the Policyholder within 30 days of such determination, and continuation will end.

Special Medicare Rule
If a You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a Covered Dependent. The continuation period for such Covered Dependents, after such termination of employment or reduction of work hours, will be the longer of:

1. 18 months (or 29 months, if the Disabled Qualified Beneficiaries provision applies) from such termination of employment or reduction of work hours; or

2. 36 months from the date of the qualified beneficiary's entitlement to Medicare.

Termination of Federal COBRA Continuation
Any continuation of insurance elected under this Federal COBRA Continuation Rights provision will terminate on the earliest of the following:

1. The date the Policy terminates; or

2. The last day of a period for which a required premium contribution was paid to Us, if the next required premium is not paid; or

3. The date a Covered Person becomes insured under another group health plan that does not exclude or limit coverage for any pre-existing condition for that Covered Person; or

4. The date the insurance would otherwise terminate as described this Plan; or

5. The date a Covered Person becomes entitled to Medicare coverage; or

6. The first day of the premium month following 30 days after the date a final determination is made by the Social Security Administration that a Covered Person is no longer disabled (but only if the Covered Person recovers from the disability after the original 18-month continuation period and prior to the end of the 29-month continuation period); or

7. The date a Covered Person has continued insurance for the maximum continuation period allowed by COBRA; or

8. The date the Policyholder ceases to provide any group health plan to Employees.

Spousal Continuation after Federal COBRA

Missouri law provides for additional continuation coverage past the expiration of Federal COBRA coverage for Covered Dependent spouses and children. A spouse seeking to elect this continuation of coverage must be at least 55 years of age at the time Federal COBRA coverage expires and the Certificate Holder must have died or the spouses became divorced or legally separated during the Federal COBRA coverage period.

A spouse seeking such continuation coverage must provide the Certificate Holder's employer with notification, which includes a mailing address. Notification must be sent before the expiration of the 36-month Federal COBRA coverage period and:

- In the event of legal separation or divorce, within 60 days of legal separation or dissolution of marriage; or
- In the event of death of Certificate Holder, within 30 days

Within 14 days after receipt of notification, the employer must notify the spouse that the policy may be continued and provide a form and instructions for election of coverage. Failure to provide such notification to the spouse will result in the spouse's coverage to continue in force and any obligation of premium payment by the spouse to be postponed until 31 days after receipt of the required notice from the employer.

The spouse has 60 days after receipt of notification from the employer to elect coverage and return the election form. The first premium is due within 45 days of election of coverage.

This continuation coverage will terminate upon the earliest date that any of the following occurs:

- Premium is not timely paid;
- The group policy is terminated for all members;
- The spouse becomes insured under any other group plan;
- The spouse remarries and becomes insured under another group plan; or
- The spouse turns 65 years of age.

Special Continuation Rights for Active Duty Military Personnel
Employees going to or returning from military service will have continuation rights mandated by the Uniformed Service Employment and Reemployment Rights Act (USERRA). These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Immediate coverage is available with no pre-existing condition exclusion applied upon return from service. These rights apply only to Certificate Holders and their Dependents who are covered under this Plan before leaving for military service.

Coverage under this USERRA provision will run concurrently with continuation coverage that would otherwise be available under COBRA.

This Plan will exclude from coverage services for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, performance of active service in the uniformed services. The determination that the Certificate Holder's Sickness or Injury was Incurred in, or was aggravated during, the performance of service may only be made by the Secretary of Veterans Affairs.

Premium Payment
The monthly premium rate charged for the continuation of insurance under this section can be obtained from the Policyholder. The full cost of this coverage, including any portion usually paid by the Policyholder, must be paid by You within 31 days after coverage under this Plan terminates due to a qualifying event. Premiums must be paid within the guidelines established by Us.

Coordination Among Continuation Rights Provisions
A Covered Person may be eligible to continue his or her group coverage under the Federal COBRA Continuation Rights provision and under the State Continuation Rights provision at the same time.

If a Covered Person elects to continue his or her group coverage under both the Federal and State Continuation Rights provisions, the continuation periods run consecutively and end independently on their own terms.

Administration of Continuation
Your employer is responsible for providing the necessary notification of continuation rights to You. Contact the Policyholder for complete details on the continuation rights for You or any Covered Dependents.

Extension of Coverage Period
In no event will the period for continuation of coverage extend beyond 36 months even though more than one qualifying event has occurred. If more than one qualifying event occurs, the duration of the continuation period will be measured from the date of the initial qualifying event.

OTHER PROVISIONS

Entire Contract
This Certificate is issued to the Certificate Holder in consideration of the Policyholder's application for coverage. The entire contract of insurance includes the Policy, the Policyholder's application, a Covered Person's enrollment form, the Covered Person's Certificate, and any riders and endorsements to the Policy or the Certificate.

Consideration
This Plan is issued based on the statements and agreements in the Covered Person's enrollment form, any exam of a Covered Person that is required, any other amendment or supplement to the enrollment form, and payment of the required premium. Each renewal premium is payable by the Policyholder on the due date, subject to the Grace Period provision in the Policy.

Certificate Changes
No change in the Certificate will be valid unless approved by one of Our executive officers and included with or issued as a supplement to this Certificate. No agent or other employee of Our Company has authority to waive or change any Plan provision or waive any other applicable enrollment or application requirements.

Clerical Error
If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have otherwise terminated in accordance with this Certificate.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

Changes to Coverage Required by Law
Coverage under this Plan may be changed as required by applicable law as of the first day of the Plan Year, or other date, specified by law or an endorsement or amendment to the Policy or Certificate.

Conformity with State Statutes
If this Policy, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this Policy, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the Policy to the contrary.

Enforcement of Plan Provisions
Failure by Us to enforce or require compliance with any provision within this Plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Credit for Deductible
A Credit for Deductible may be provided under this Plan. The Benefit Summary will indicate if the Credit for Deductible is included in this Plan.

For a Covered Person who was covered under his or her Policyholder's prior group plan for 12 months on the day that plan was replaced by Our Policy, We may credit the amount that was Incurred and applied to the Covered Person's Deductible under the prior plan for the same Calendar Year under this Plan. A Covered Person must provide Us with proof of the Deductible amount that was satisfied under the prior plan.

Any amount subject to this provision that We credit to an applicable Deductible under this Plan, will also be credited to any applicable Out-of-Pocket Limit under this Plan for the same Year.

Family Support Services
We may elect to furnish or participate in programs with other organizations that furnish family support services and goods to You at no charge or at a discount. Family support services are services designed to assist the Covered Person's family or other caregivers with facilitating delivery of or access to covered treatment.

Representations
All statements made by the Covered Person during enrollment are considered representations, not warranties. No statement made in the enrollment form will be used in any suit or action at law or equity unless a copy of the enrollment form is furnished to the Covered Person, or in the event of death or incapacity of the Covered Person, a copy will be furnished to the Covered Person's beneficiary or personal representative.

Misstatements
In the absence of fraud, a statement made by the Certificate Holder or a Covered Person is considered a representation and not a warranty. If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums might be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us. No statement made in the enrollment form will be used in any suit or action at law or equity unless a copy of the enrollment form is furnished to the Certificate Holder.

Rescission of Insurance and/or Denial of Claim
Within the first two years after the Effective Date of coverage, We have the right to modify Your Certificate of insurance coverage, rescind coverage, and/or deny a claim for a Covered Person if the enrollment form contains an intentional omission or intentional misrepresentation of a material fact that We determine to be material. In the event of an intentional omission or intentional misrepresentation of a material fact, We will provide You with 30 days advance written notice. We also reserve the right to deny a claim if Covered Person has performed an act or practice that constitutes fraud at any time during the coverage period.

During the first two years after the date of the Policyholder's application, We have the right to modify the Policy and/or rescind coverage if the Policyholder's application contains an intentional omission or intentional misrepresentation that We determine to be material. We will

give the Policyholder 30 day's notes prior to such a rescission of the Policy.

Legal Action
No suit or action at law or in equity may be brought to recover benefits under this Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No suit or action at law or in equity can be brought later than 6 years from the date written proof of loss has been furnished in accordance with the requirements of this Certificate.

Modification of Your Coverage
We may modify the health insurance coverage for You and Your Covered Dependents. This modification will be consistent with state law and will apply uniformly to all group health plans with Your Plan of coverage. You will be notified of any change. If the change involves a material modification, as defined by federal law, that affects the content of the summary of benefits and coverage (SBC), and does not coincide with the renewal or reissuance of coverage, We will give You 60 days' notice prior to the date on which the modification will become effective. The Outpatient Prescription Drug coverage can only be modified when Your Plan is renewed. We will give the Policyholder 60 days' notice prior to any change in Outpatient Prescription Drug coverage.

DEFINITIONS

When reading this Certificate, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this Plan are defined below. Just because a term is defined does not mean it is covered. Please read the Certificate carefully.

90-Day Prescription Drug Provider
A licensed Pharmacy, including but not limited to a mail order service, that has agreed to Our terms and conditions, including reimbursement amounts, to provide 90-day supplies of covered Prescription Drugs under this Plan.

Accident or **Accidental**
Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.

2. It results from an external agent or trauma.

3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.

4. It is definite as to time and place.

5. It happens involuntarily, or entails unforeseeable consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.

Acute Behavioral Health Inpatient Facility
A facility that provides acute care or Subacute Medical Care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations to provide acute care or Subacute Medical Care for Behavioral Health or Substance Abuse:

    a. The Joint Commission (TJC).
    b. Commission on the Accreditation of Rehabilitation Facilities (CARF).
    c. Council on Accreditation (COA).
    d. Det Norske Ventius Healthcare, Inc. (DNV).
    e. Accreditation Association for Ambulatory Health Care (AAAHC).
    f. Accreditation Commission for Health Care (ACHC).
    g. Healthcare Facilities Accreditation Program (HFAP).

2. Be staffed by an on duty licensed physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily medical records that document all services provided for each patient.

5. Provide a restrictive environment for patients who present a danger to self or others.

6. Provide alcohol and chemical dependency detoxification services.

7. Handle medical complications that may result from a Behavioral Health or Substance Abuse condition.

8. Not primarily provide Rehabilitative Services, residential, partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.

Participation in the Health Care Provider Network does not guarantee that the facility meets all of the above requirements.

Acute Medical Rehabilitation Facility
A facility that provides acute care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. A distinct section of a Hospital solely devoted to providing acute care for Rehabilitative Services would also qualify as an Acute Medical Rehabilitation Facility. These types of facilities must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations to provide acute care for Rehabilitative Services:

    a. The Joint Commission (TJC).
    b. Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).
    c. Center for Improvement in Healthcare Quality (CIHQ).
    d. Commission on Accreditation of Rehabilitation Facilities (CARF).

2. Be staffed by an on duty physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Provide an initial, clearly documented care plan upon admission and ongoing care plans for patients on a regular basis that include reasonable, appropriate and attainable short and intermediate term goals.

5. Provide a total of 3 hours per day, at least 6 days per week, of any combination of active Physical Therapy, Occupational Therapy, and Speech Therapy by an appropriately licensed Health Care Practitioner to each patient. A Covered Person must be able and willing to participate actively in these services for at least the above referenced time frames.

    Cognitive therapy, counseling services, passive range of motion therapy, respiratory therapy, and similar services are not included in the 3 hour minimum per day requirement of active Physical Therapy, Occupational Therapy, and Speech Therapy.

6. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

Participation in the Health Care Provider Network does not guarantee that the facility meets all

of the above requirements.

Administrator
An organization or entity designated by Us to manage the benefits provided in this Plan. The designated Administrator will have the authority to act on Our behalf in the administration of this Plan. The Administrator may enter into agreements with various providers to provide services covered under this Plan.

Ancillary Charge
The difference in cost between a Brand Name Drug and what We will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy or Designated Specialty Pharmacy Provider.

Ancillary Charge also includes the difference in cost between a Brand Name Drug and a Bio-Similar Drug when a Bio-Similar Drug substitute exists but the Brand Name Drug is dispensed.

The Ancillary Charge does not count toward satisfying any Cost-Sharing.

Approved Clinical Trial
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 from which the likelihood of death is probable unless the course of the disease or condition is interrupted and is described in any of the following:

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

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. The U.S. Food and Drug Administration.
    f. Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
    g. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    h. The Department of Veterans Affairs, if the conditions for department are met.
    i. The Department of Defense, if the conditions for department are met.
    j. The Department of Energy, if the conditions for department are met.
    k. An institutional review board of an institution in Missouri that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

2. The phase II study or investigation is sanctioned by the National Institutes of Health or the National Cancer Institute (NCI) and conducted at an academic or NCI center.

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

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

Assistant Surgeon
A Health Care Practitioner who is qualified by licensure, training, and credentialing to perform the procedure in an assistant role to the primary surgeon in the state and facility where the procedure is performed.

Average Sales Price (ASP)
A published cost of a Prescription Drug, as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.

Average Wholesale Price (AWP)
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler, as listed by Our national drug data bank on the date the Prescription Drug is purchased.

Behavioral Health
Any condition classified as a mental disorder, which includes eating disorders, in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us.

Behavioral Health Rehabilitation and Residential Facility
A facility that provides care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility may also be referred to as a residential facility, and must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations to provide residential care for Behavioral Health or residential/rehabilitation care for Substance Abuse:

    a. The Joint Commission (TJC).
    b. Commission on the Accreditation of Rehabilitation Facilities (CARF).
    c. Council on Accreditation (COA).
    d. Det Norske Ventius Healthcare, Inc. (DNV).
    e. Accreditation Association for Ambulatory Health Care (AAAHC).
    f. Accreditation Commission for Health Care (ACHC).
    g. Healthcare Facilities Accreditation Program (HFAP).

2. Be staffed by an on-call physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Provide an initial evaluation by a physician upon admission and ongoing evaluations for patients on a regular basis.

5. Provide a restrictive environment for patients who present a danger to self or others.

6. Provide 3 hours of individual or group psychotherapy per day, at least 6 days per week, by an appropriately licensed Health Care Practitioner. Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy, and similar services may be provided but are not included in the 3 hour per day minimum psychotherapy

requirement.

7. Be able to handle medical complications that may result from a Substance Abuse diagnosis.

8. Not primarily provide partial hospitalization or intensive Outpatient services, although these services may be provided in a distinct section of the same physical facility.

Participation in the Health Care Provider Network does not guarantee that the facility meets all of the above requirements.

Bio-Similar Drug
An FDA-approved biological product that is nearly the same as another U.S.-licensed reference biological product except for differences in clinically inactive components and for which there are no clinically meaningful differences in safety and potency between the biological product and the reference product.

Brand Name Drug
A Prescription Drug for which a pharmaceutical company has received a patent or trade name.

Calendar Year
The period beginning on January 1st of any year and ending on December 31st of the same year.

Cardiac Rehabilitation Program
An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.

Certificate
A Certificate Holder's evidence of coverage under the Group Major Medical Policy.

Certificate Holder
The person to whom this Certificate is issued. The Certificate Holder is listed as the subscriber in the coverage summary on the member web portal.

Clinical Trial Qualified Individual
A Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either:

1. The referring Health Care Practitioner is a Participating Provider and has concluded that the Covered Person's participation in such trial would be appropriate based on the trial protocol; or

2. The Covered Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon the trial protocol.

Coinsurance
The percentage of Covered Charges that must be paid, after any other applicable Cost-Sharing is satisfied.

1. **Covered Person Coinsurance**
   The Coinsurance each Covered Person pays. Coinsurance applies separately to each Covered Person, except as otherwise provided by this Plan.

2. **Plan Coinsurance**
   The Coinsurance We pay. It applies to all Covered Charges unless otherwise noted in this Certificate.

The Benefit Summary will identify the applicable Coinsurance, the Coinsurance percentage, and the Covered Charges to which it applies.

Complications of Pregnancy
Health conditions distinct from pregnancy but that are adversely affected by or caused by pregnancy. This includes:

1. Ectopic pregnancy; spontaneous (miscarriage) or missed abortion; acute nephritis; cardiac decompensation; disease of the vascular, nervous or endocrine systems; preeclampsia; eclampsia; hyperemesis gravidarum; and similar medical or surgical conditions of comparable severity.
2. An Emergency or non-elective caesarean section. This does not include a caesarean section performed because a previous pregnancy resulted in a caesarean section.

Complications of Pregnancy do not include: false labor, occasional spotting, rest prescribed during the period of pregnancy, or elective cesarean section.

Compounded Medication
A drug product made up of two or more active parts or ingredients, which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered Non-Preferred Brand Name Drugs.

Contracted Rate
The amount a Health Care Practitioner, Pharmacy, facility, or supplier that has a contract with Us, or with the Health Care Provider Network identified for this Plan, has agreed to accept as total payment for the treatment, services, supplies, or Prescription Drugs provided.

Copayment
The dollar amount that must be paid by a Covered Person each time a Covered Charge is Incurred.

A Copayment applicable to a Prescription Drug dispensation is subject to the Supply Limits, as outlined in the Outpatient Prescription Drug Benefits section.

A Copayment only applies if it is shown on the Benefit Summary. The Benefit Summary will identify any applicable Copayment and the Covered Charges to which it applies.

Correspondence Address
[PO Box 2070
Milwaukee, WI 53201-2070]

Cosmetic Service
A surgery, procedure, injection, medication, or treatment primarily designed to improve

appearance, self-esteem, or body image and/or to relieve or prevent social, emotional, or psychological distress.

Reconstructive Surgery is not considered a Cosmetic Service.

Cost-Sharing
The share of costs for a Covered Charge that a Covered Person must pay. One or more of the following Cost-Sharing features may apply to Covered Charges, as shown in the Benefit Schedule:

1. Access fee
2. Covered Person Coinsurance.
3. Copayment.
4. Deductible.
5. Out-of-Pocket Limit.

Covered Charge
A charge as a result of, or related to, Sickness or Injury, or for preventive services as outlined in the Medical Benefits section, that We determine is:

1. Incurred by a Covered Person while coverage under this Certificate is in force.
2. Incurred for services, treatment, or supplies prescribed by or performed by a Health Care Practitioner, Pharmacy, facility, or supplier.
3. Incurred for Medically Necessary care.
4. Incurred for services, treatment, or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section, and not otherwise excluded by this Certificate.

Covered Charge does not include any charge in excess of the Maximum Allowable Amount.

Covered Dependent
A person who meets the definition of a Dependent and who is enrolled in and eligible to receive benefits under this Plan.

Covered Person
A person who is enrolled, who is eligible to receive benefits, and for whom coverage is effective under this Certificate.

Creditable Coverage
Coverage under any of the following, provided such coverage does not precede a break in coverage of 63 consecutive days or more, not counting any waiting period or affiliation period required by any Creditable Coverage:

1. A group health plan.

2. Health insurance coverage.

3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

4. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.10 U.S.C. Ch. 55.

5. A health or medical care program provided through the Indian Health Service or a tribal organization.

6. A state health benefits risk pool.

7. A health plan offered under 5 U.S.C. Ch. 89.

8. A public health plan as defined under federal regulations.

9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

10. An organized delivery system licensed by the director of public health.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits. Excepted benefits include, but are not limited to:

1. Coverage only for accidents, including accidental death and dismemberment.

2. Disability income insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Coverage issued as a supplemental to liability insurance.

5. Workers' compensation or similar insurance.

6. Automobile medical payment insurance.

7. Credit-only insurance, such as mortgage insurance.

8. Coverage for on-site medical clinics.

9. A plan covering only ancillary benefits.

10. A limited benefit insurance plan.

11. Discount cards and other products that are not considered insurance coverage.

Currently Performing Services
An Employee of the Policyholder who works on a Full-Time Basis and regularly performs services for the employer. Individuals Currently Performing Services do not include retirees or Employees on non-medical leave who are not expected to perform any duties, responsibilities, or services for the employer.

Custodial Care
Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards.

2. Is provided primarily to assist in the activities of daily living including, but not limited to: help with walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or, supervision of medication that can usually be self-administered and does not entail or require the continuing services of licensed medical personnel.

3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

Deductible
A Deductible is the dollar amount of Covered Charges that must be paid by the Covered Person before benefits are paid by Us under the Plan.

This Certificate has varying types of Deductibles. This may depend on whether the Covered Person's Health Care Practitioner belongs to the Health Care Provider Network or not.

One or more of the following Deductibles may apply to Covered Charges, as shown on the Benefit Summary:

1. **Individual Deductible**
   The dollar amount of Covered Charges that must be paid by the Covered Person before benefits are paid by Us. When such Covered Person Incurs Covered Charges processed by Us that equal the Individual Deductible, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Year. Once a Covered Person's Individual Deductible is satisfied, Covered Charges for that Covered Person will not count toward the Family Deductible for the remainder of the Year.

   a. **Individual Participating Provider Deductible**
      The Individual Deductible Incurred from Participating Providers.
   b. **Individual Non-Participating Provider Deductible**
      The Individual Deductible Incurred from Non-Participating Providers.

2. **Family Deductible**
   The dollar amount of Covered Charges that must be paid by all Covered Persons before benefits are paid by Us. The Individual Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount. When the Family Deductible is reached, the Deductible requirements for all Covered Persons in Your family will be considered satisfied for the remainder of the Year. If a Family Plan only includes two Covered Persons, each Covered Person must meet the Individual Deductible.

   a. **Family Participating Provider Deductible**
      The Family Deductible Incurred from Participating Providers.
   b. **Family Non-Participating Provider Deductible**

The Family Deductible Incurred from Non-Participating Providers.

The Benefit Summary will identify any applicable Deductibles and the Covered Charges to which they apply.

Dental Hygienist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to practice dental hygiene under the supervision of a Dentist. The Dental Hygienist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dental Injury
An Injury to the mouth causing trauma to natural teeth, the mouth, gums, or supporting structures of the teeth. Dental Injury does not include Injury to the teeth as a result of chewing.

Dental Treatment
Any dental consultation, service, treatment, procedure, or supply that is needed for the care of the teeth and supporting tissues.

Dental Treatment Plan
A Dentist's report of recommended treatment, or orthodontist's report of recommended Orthodontic Treatment, on a form satisfactory to Us that:

1. Itemizes the dental procedures and charges required for care of the mouth.

2. Lists the charges for each procedure.

3. Is accompanied by supporting preoperative imaging tests, and any other appropriate diagnostic materials required by Us.

Dentist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to practice dentistry. The Dentist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Denturist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to make dentures. The Denturist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dependent
A Dependent is:

1. The Certificate Holder's lawful spouse; or

2. A child who is age 25 or younger at the time of enrollment in this Plan, that is the Certificate Holder's naturally born child, stepchild, legally adopted child, child that is placed for adoption with the Certificate Holder, child for which the Certificate Holder is the legal guardian, or child for whom the Certificate Holder is required to provide coverage by a court or administrative order, a National Medical Support Notice, or a Title IV-D support case of the Social Security Act.

3. A child who is age 26 or older that is incapable of self-sustaining employment because of intellectual or physical disability and is chiefly dependent on the Certificate Holder for support and maintenance. To obtain coverage, proof of child's incapacity and dependency must be provided not later than 31 days after attaining age 26 and not more than once a year thereafter, as required.

For the purposes of the Dependent definition, a child is considered placed for adoption with the Certificate Holder if the Certificate Holder is party in a suit for adoption of the child.

Designated Eyewear Provider
A Participating Provider identified as a Designated Eyewear Provider to dispense the covered Pediatric Eyewear Collection to Covered Persons under this Plan's Child Vision Services provision. A Participating Provider will only be considered a Designated Eyewear Provider when they are designated as such by Us or by Our Eyewear Benefit Manager for the specific eyewear being obtained. Provider designations are subject to change at any time without notice.

[A Designated Eyewear Provider is a [VSP provider].]

Designated Specialty Pharmacy Provider
A Participating Pharmacy or Participating Provider identified as a Designated Specialty Pharmacy Provider to dispense specific Specialty Pharmaceuticals to Covered Persons under this Plan. A Participating Pharmacy or Participating Provider will only be considered a Designated Specialty Pharmacy Provider when they are designated as such by Us for the specific Specialty Pharmaceutical being obtained. Provider designations are subject to change at any time without notice.

Designated Transplant Provider
A Participating Provider identified as a Designated Transplant Provider to provide transplant services to Covered Persons under this Plan. A Participating Provider will only be considered a Designated Transplant Provider when they are designated as such by Us for the specific transplant being obtained. Provider designations are subject to change at any time without notice.

Developmental Delay
A delay in attaining developmental milestones for the child's age, adjusted for prematurity, in one or more of the following areas of development: cognitive; physical (including vision and hearing); communication; social-emotional; or adaptive development.

A Developmental Delay must be measured by qualified personnel using informed clinical opinion and appropriate diagnostic procedures and/or instruments. A Developmental Delay must be documented as:

1. A 12 month delay in one functional area.

2. A 33% delay in one functional area, or a 25% delay in each of two areas (when expressed as a quotient of developmental age over chronological age).

3. A score of at least 2.0 standard deviations below the mean in one functional area, or a score of at least 1.5 standard deviations below the mean in each of two functional areas if appropriate standardized instruments are individually administered in the evaluation.

Diagnostic Imaging
Procedures and tests that are performed to diagnose a condition or determine the nature of a condition, including, but not limited to: x-rays, magnetic resonance imaging (MRI), ultrasound, nuclear medicine, radiology, electrocardiogram (EKG), electroencephalograph (EEG), and computerized tomography scan (CT).

Drug List
The list(s) of Prescription Drugs that We designate as eligible for benefit consideration under this Plan. There may be more than one Drug List, including but not limited to a separate list for Specialty Pharmaceuticals. An applicable Drug List shows the tier and benefit category assigned to each covered Prescription Drug. The Drug Lists are reviewed annually and are subject to change at any time.

Durable Medical Equipment
Equipment that meets all of the following requirements:

1. It is designed for and able to withstand repeated use.
2. It is primarily and customarily used to serve a medical purpose.
3. It is used by successive patients.
4. It is suitable for use at home.
5. It is normally rented.

Effective Date
The date coverage under this Certificate begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.

Eligibility Date
The date You and Your Dependents are first eligible to apply for coverage under this Plan.

Emergency
A life threatening medical condition of a recent onset and severity, including severe pain that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, Sickness, or Injury, is of such a nature that failure to get immediate medical care, regardless of the final diagnosis, could result in:

1. Placing the Covered Person's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.
4. Serious disfigurement.
5. Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Care or **Emergency Treatment**

Treatment, services, or supplies provided for in a Hospital Emergency Facility, Freestanding Facility, or comparable Emergency facility to evaluate and Stabilize an Emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

Emergency Confinement
An Inpatient stay resulting from an Emergency medical condition.

Emergency Room
A place affiliated with and physically connected to a Hospital, including a free-standing emergency medical care facility or comparable emergency facility, and used primarily for short term treatment of an Emergency.

Employee
A person that is employed by the Policyholder. An Employee must:

1. Receive monetary compensation from the Policyholder.

2. Be considered an Employee for federal employment tax purposes by the Policyholder, except for partners or sole proprietors.

A person who is laid off, retired, a consultant, or on the board of directors will not be considered an Employee.

Employment Waiting Period
A period of consecutive days during which You must be Currently Performing Services for the Policyholder before You are eligible to obtain coverage under this Certificate.

Experimental or Investigational Services
Treatment, services, or supplies that, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury.

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury.

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol.

4. Obsolete or ineffective for the treatment of a Sickness or an Injury.

5. Medications used for non-FDA approved indications and/or dosage regimens.

Eyewear Benefit Manager
An organization or entity, designated by Us, to:

1. Administer and maintain the Pediatric Eyewear Collection.

2. Designate HealthCare Practitioners, facilities, or suppliers as Designated Eyewear Providers for purposes of the Child Vision Services provision.

3. Provide treatment, services, or supplies as a Designated Eyewear Provider pursuant to the Child Vision services provision.

[The Eyewear Benefit Manager is [VSP].]

Family Plan
A Plan covering the Certificate Holder and one or more of the Certificate Holder's Dependents.

Free-Standing Facility
A facility that provides services, on an Outpatient basis, which require hands-on care by a Health Care Practitioner and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, a diagnostic testing facility, a facility that exclusively performs endoscopic procedures, or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide Outpatient services and administer anesthesia or conscious sedation is also considered a Free-Standing Facility. These facilities must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility and be accredited by one of the following accreditations:

    a. The Joint Commission (TJC).
    b. Accreditation Association for Ambulatory Health Care (AAAHC).
    c. American Association of Ambulatory Surgery Facilities (AAASF).
    d. Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

2. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

Full-Time Basis
An Employee who works at least 30 hours per week. A temporary, seasonal, or part-time Employee will not be considered an Employee working on a Full-Time Basis.

Generic Drug
An Outpatient Prescription Drug that is identified as a Generic Drug on Our Drug List. A drug identified as generic by the manufacturer, Pharmacy, or Your Health Care Practitioner may not be classified as a Generic Drug by Us.

A Generic Drug identified on Our Drug list is a Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug.

2. Does not carry any drug manufacturer's brand name on the label.

3. Is not protected by a patent.

4. Is listed as a Generic Drug by Our national drug data bank on the date it is purchased.

Compounded Medications are not Generic Drugs.

Medications that are commercially manufactured together and/or packaged together are not considered Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased, and is identified as a Generic Drug on Our Drug List.

Habilitative Services
Specialized treatment for a disabling condition, including Developmental Delay, which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.

2. Is designed for the Covered Person to attain and maintain a skill or function and independence that was never learned or acquired.

3. Is under the direction of a qualified Health Care Practitioner.

4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

5. Is provided in either an Inpatient or Outpatient setting.

Health Care Practitioner
A person licensed by the state or other geographic area in which the Covered Charges are rendered to provide preventive or wellness services, or to treat the kind of condition, Sickness, or Injury for which a claim is made, including a chiropractor. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

A Health Care Practitioner does not include an Immediate Family Member.

Health Care Provider Network
The group of Health Care Practitioners, Pharmacies, facilities, and suppliers, identified by Us or the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services, supplies, or Prescription Drugs provided, except for Designated Specialty Pharmaceuticals.

For Specialty Pharmaceuticals, only Designated Specialty Pharmacy Providers who have agreed to accept a Contracted Rate as payment in full for specific Specialty Pharmaceuticals are considered members of the Health Care Provider Network.

Network status is subject to change at any time without notice.

Home Health Care
Services provided by a state licensed Home Health Care Agency as part of a program for care and treatment in a Covered Person's home.

Home Health Care Agency
An organization:

1. Whose primary purpose is to provide Home Health Care.

2. That is accredited by:

    a. The Joint Commission (TJC).
    b. Community Health Accreditation Partner (CHAP).
    c. Accreditation Commission for Health Care (ACHC)

3. That is licensed as a Home Health Care Agency by the state in which it provides services.

Home Office
Our office in [Winston-Salem, North Carolina], or other administrative offices as indicated by Us.

Hospice
An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill, as certified by a physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements.

2. Provide a treatment plan and services under the direction of a physician.

3. An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:

4. Be a dedicated unit within a Hospital or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.

5. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.

6. Be staffed by an on call physician 24 hours per day.

7. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

8. Maintain daily clinical records.

9. Admit patients who have a terminal illness.

10. Not provide patients with services that involve active intervention for the terminal illness, although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.

Hospital (Acute Medical Facility)
A facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility, and must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and operated pursuant to applicable state and federal laws.
2. Be staffed by an on duty physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily medical records that document all services provided for each patient.

5. Provide immediate access to appropriate in-house laboratory and imaging services.

6. Not primarily provide care for Behavioral Health or Substance Abuse, although these services may be provided in a distinct section of the same physical facility.

7. Provide care in an Intensive Care Unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU), and step-down units.

Immediate Family or **Immediate Family Member**
An Immediate Family Member is:

1. A Covered Person.

2. A Covered Person's spouse.

3. The children, brothers, sisters, and parents of either a Covered Person or their spouse.

4. The spouses of the children, brothers, sisters, and parents of either a Covered Person or their spouse.

5. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

Incur or **Incurred**
The date services are provided or supplies are received.

Injury
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally. The Injury must be definite to a single time and place.

Inpatient
Admitted to an Acute Behavioral Health Inpatient Facility, a Hospital, or other licensed facility for a stay of at least 24 hours for which a charge is Incurred for room and board or observation.

Intensive Care Unit
That part of a hospital service specifically designed as an Intensive Care Unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

Intensive Outpatient Behavioral Health Program
A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the

following accreditations to provide care for Behavioral Health or Substance Abuse:

a. The Joint Commission (TJC).
b. Commission on the Accreditation of Rehabilitation Facilities (CARF).
c. Council on Accreditation (COA).
d. Det Norske Ventius Healthcare, Inc. (DNV).
e. Accreditation Association for Ambulatory Health Care (AAAHC).
f. Accreditation Commission for Health Care (ACHC).
g. Healthcare Facilities Accreditation Program (HFAP).

2. Provide at least 2 hours of individual or group psychotherapy a day, at least 3 days per week, by an appropriately licensed Health Care Practitioner. Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy, and similar services are not included in the 6 hours per week minimum psychotherapy requirement.

Late Entrant
A person:

1. Who did not apply for coverage under this Plan within 31 days after the Eligibility Date for the Employee or Dependent.

2. Whose coverage under this Plan was previously terminated because a required premium contribution was not paid.

3. Who did not apply for coverage under this Plan, if the person was a Dependent on the date the initial enrollment form was completed by the Employee.

Mail Service Prescription Drug Vendor
A Participating Pharmacy that is under contract with Our Network Manager or Us through Our Participating Pharmacy Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.

Malocclusion
Teeth that do not fit together properly which creates a bite problem.

Mandibular Protrusion or Recession
A large chin that causes an underbite or a small chin that causes an overbite.

Maxillary or Mandibular Hyperplasia
Excess growth of the upper or lower jaw.

Maxillary or Mandibular Hypoplasia
Undergrowth of the upper or lower jaw.

Maximum Allowable Amount
The amount of a billed charge We determine to be payable for Covered Charges. The Maximum Allowable Amount is sometimes referred to as the usual or customary charge.

Amounts billed in excess of the Maximum Allowable Amount are not payable by Us. Please see the Provider Charges and Maximum Allowable Amount Provisions section for the method(s) We

use to determine the Maximum Allowable Amount.

Maximum Allowable Cost (MAC) List
A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level or at Prescription Drug Class level based on the Prescription Drug Class Reference Price that is established by Us. This list is subject to change at any time without notice.

Maximum Benefit
The maximum amount, as shown on the Benefit Summary, that We will consider as Covered Charges Incurred by each Covered Person under this Plan. When the Maximum Benefit has been reached, no other benefits are considered as Covered Charges for that for that Covered Person for the treatment, services, or supplies to which the maximum applies.

Medical Review Manager
Our Company, or an organization or entity, designated by Us, which may:

1. Review services in accordance with the Pre-Authorization and Other Utilization Review Provisions section.

2. Perform discharge planning and case management services.

3. Evaluate the Medical Necessity of treatment, services, or supplies.

4. Review a Covered Person's Behavioral Health or Substance Abuse condition and evaluate the Medical Necessity of referral treatment.

5. Review and administer authorization under Our Specialty Pharmacy Program.

Medical Supplies
Disposable medical products or Personal Medical Equipment that are used alone or with Durable Medical Equipment.

Medical Supply Provider
Agencies, facilities, or wholesale or retail outlets that make Medical Supplies available for use.

Medically Necessary or **Medical Necessity**
For medical treatment:
Treatment, services, or supplies that are rendered to diagnose or treat a Sickness or an Injury, and that We determine:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment of the Sickness or Injury.

2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines.

3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury.

4. Is provided in the most conservative manner or in the least intensive setting without

adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service, or supply does not, of itself, make it Medically Necessary for the purpose of coverage under this Certificate.

For dental treatment:
For purposes of dental coverage under this Certificate, Medically Necessary means Dental Treatment or Orthodontic Treatment rendered to diagnose or treat a dental or orthodontic condition that left untreated would likely result in medical or functional impairment, and that We determine:

1. Is essential for the care of the teeth and supporting tissues.

2. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment of the condition.

3. Is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines.

4. Can reasonably be expected to result in or contribute substantially to the improvements of a condition.

5. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of care provided.

6. Is not rendered for cosmetic reasons.

The fact that a Health Care Practitioner may prescribe, order, recommend, or approve a treatment, service, or supply does not, of itself, make it Medically Necessary for the purpose of coverage under this Certificate.

For vision treatment:
For purposes of vision coverage under this Certificate, Medically Necessary means vision services rendered to diagnose or treat a vision condition, and that We determine:

1. Is essential for the care of the eyes and sight.

2. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment of the condition.

3. Is commonly accepted as proper care or treatment of the condition in accordance with United States ophthalmologic standards and federal government guidelines.

4. Can reasonably be expected to result in or contribute substantially to the improvements of a condition.

5. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend, or approve a treatment, service, or supply does not, of itself, make it Medically Necessary for the purpose of coverage under this Certificate.

Medicaid
Title XIX of the Social Security Act, and its implementing regulations, all as amended.

Medicare
Any portion of the Health Insurance for the Aged Act, Title XVIII of the United States Social Security Act of 1965, and its implementing regulations, all as amended.

Negotiated Rate
The amount negotiated between Us, or on behalf of Us, and the Health Care Practitioner, Pharmacy, facility, or supplier as total payment for the services, treatment, supplies, or Prescription Drugs provided, except for Specialty Pharmaceuticals, where it is the amount negotiated only between Us and the Health Care Practitioner, facility, supplier, or Pharmacy as total payment for the Specialty Pharmaceuticals provided. The Negotiated Rate may include any discount arrangement We may have with the Health Care Practitioner, facility, or supplier.

Network Manager
An organization or entity, designated by Us, which may administer the Health Care Provider Network.

The Network Manager's name is shown on the insurance coverage identification (ID) card.

Non-Participating Pharmacy
Any Pharmacy that is not participating in the Health Care Provider Network. Network status is subject to change.

When obtaining Specialty Pharmaceuticals, any Pharmacy not designated as a Designated Specialty Pharmacy Provider for the specific Specialty Pharmaceutical being dispensed is considered a Non-Participating Pharmacy.

Non-Participating Provider
Any Health Care Practitioner, Pharmacy, facility, or supplier that is not participating in the Health Care Provider Network. Network status is subject to change.

When obtaining Specialty Pharmaceuticals, any provider not designated as a Designated Specialty Pharmacy Provider for the specific Specialty Pharmaceutical being dispensed is considered a Non-Participating Provider.

Occupational Therapy
The treatment of Sickness or Injury by a Health Care Practitioner using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills.

2. Strengthening and enhancing function.

3. Coordination of fine motor skills.

4. Muscle and sensory stimulation.

Office Visit
An in-person meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office, or a Telehealth (virtual) visit between a Covered Person and a Health Care Practitioner. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury or provides routine preventive services.

Office Visit does not include Physical Therapy, Speech Therapy, or Occupational Therapy, even if rendered in an office setting or via Telehealth. Office Visit does not include any separately billed facility fee.

Orthodontic Treatment
The corrective movement of teeth through the bone by means of an active appliance to correct a handicapping Malocclusion (a Malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the Malocclusion.

Outcome Improvement Program
Our program(s) and guidelines providing a special arrangement by which We may provide benefits to Covered Person(s) to promote, facilitate, or assist with treating, controlling or managing certain conditions or encouraging healthy outcomes.

Out-of-Pocket Limit
The Out-of-Pocket Limit is the maximum amount of Cost-Sharing that each Covered Person is responsible for paying for Covered Charges each Year.

Once the Out-of-Pocket Limit is reached, We will pay for Covered Charges at 100% for the remainder of the Year. Covered Charges are still subject to the Maximum Allowable Amount and any applicable Maximum Benefit limits. The Benefit Summary will identify any applicable Out-of-Pocket Limits and the Covered Charges to which they apply.

This Certificate has varying types of Out-of-Pocket Limits.

1. **Individual Out-of-Pocket Limit**
   The dollar amount of Cost-Sharing that must be paid by each Covered Person before the Individual Out-of-Pocket Limit is satisfied for that Covered Person for the remainder of the Year.

   a. **[Individual Participating Provider Out-of-Pocket Limit**
      The Individual Out-of-Pocket Limit for Covered Charges Incurred from Participating Providers.
   b. **Individual Non-Participating Provider Out-of-Pocket Limit**
      The Individual Out-of-Pocket Limit for Covered Charges Incurred from Non-Participating Providers.]

2. **Family Out-of-Pocket Limit**
   The dollar amount of Cost-Sharing that must be paid by [You and Your Covered Dependents][at least [2-5] Covered Persons] before the Family Out-of-Pocket Limit is satisfied for all Covered Persons under the same Family Plan for the remainder of the Year.

a. **[Family Participating Provider Out-of-Pocket Limit**
The Family Out-of-Pocket Limit for Covered Charges Incurred from Participating Providers.
b. **Individual Non-Participating Provider Out-of-Pocket Limit**
The Family Out-of-Pocket Limit for Covered Charges Incurred from Non-Participating Providers.]

The following do not count toward satisfying any Out-of-Pocket Limit:

1. Any applicable penalty applied under the Pre-Authorization and Other Utilization Review Provisions section.

2. Amounts in excess of the Maximum Allowable Amount.

3. Charges Incurred after any applicable Maximum Benefit has been paid.

4. Ancillary Charges.

5. Charges for Specialty Pharmaceuticals obtained from a provider that is not a Designated Specialty Pharmacy Provider.

6. Any Non-Participating Provider charge for which the Benefit Summary states Coinsurance does not apply to the Out-of-Pocket Limit.

7. Charges that are not Covered Charges.

8. Your monthly premiums.

Outpatient
Treatment, services, supplies, or Prescription Drugs received at a licensed medical facility, Health Care Practitioner's office, or Pharmacy on other than an Inpatient basis. Room and board and overnight services are not covered.

Partial Hospital and Day Treatment Behavioral Health Facility or Program
A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following accreditations to provide care for Behavioral Health or Substance Abuse:

    a. The Joint Commission (TJC).
    b. Commission on the Accreditation of Rehabilitation Facilities (CARF).
    c. Council on Accreditation (COA).
    d. Det Norske Ventius Healthcare, Inc. (DNV).
    e. Accreditation Association for Ambulatory Health Care (AAAHC).
    f. Accreditation Commission for Health Care (ACHC).
    g. Healthcare Facilities Accreditation Program (HFAP).

2. Provide at least 4 hours of individual or group psychotherapy a day, between 3-5 days

per week, by an appropriately licensed Health Care Practitioner.

Recreational therapy, educational therapy, music and dance therapy, exercise, yoga, equine therapy, and similar services are not included in the 12 hour per week minimum psychotherapy requirement.

Participating Pharmacy
A Pharmacy that is participating in the Health Care Provider Network or the Participating Pharmacy Network. A Participating Pharmacy has agreed to accept a Contracted Rate as payment in full for the Prescription Drugs provided to the Covered Person through Our Participating Pharmacy Network or Our Health Care Provider Network. Network status is subject to change at any time.

Participating Pharmacy Network
A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. For purposes of obtaining Specialty Pharmaceuticals, only Designated Specialty Pharmacy Providers are considered members of the Participating Pharmacy Network. Network status is subject to change at any time.

Participating Provider
Any Health Care Practitioner, Pharmacy, facility, or supplier that is participating in the Health Care Provider Network. A Participating Provider has agreed to accept a Contracted Rate as payment in full for the treatment, services, or supplies provided.

For purposes of obtaining Specialty Pharmaceuticals, only Designated Specialty Pharmacy Providers are considered members of the Health Care Provider Network.

For purposes of Child Vision Services eyewear benefits, only Designated Eyewear Providers are considered members of the Health Care Provider Network, and only when the eyewear dispensed to the Covered Person is part of Our Pediatric Eyewear Collection.

Network status is subject to change at any time without notice.

Pediatric Eyewear Collection
The collection of eyewear, including glasses, lenses, frames, and contact lenses, designated by Our Eyewear Benefit Manager for coverage under the Child Vision Services provision. [The Pediatric Eyewear Collection is the [Otis and Piper Eyewear Collection].

Periodontal Maintenance Procedure
The recall procedures for Covered Persons who have undergone either surgical or non-surgical Dental Treatment for periodontal disease. The procedures may include Medically Necessary examination, periodontal evaluation, and any further scaling and root planning.

Personal Medical Equipment
Equipment, such as a prosthesis, that meets all of the following:

1. Is designed for and able to withstand repeated use.

2. Is primarily and customarily provided to serve a medical purpose.

3. Is not intended for use by successive patients.

Pharmacy
A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physical Medicine
The treatment of physical conditions relating to bone, muscle, or neuromuscular pathology. This treatment focuses on restoring function using mechanical or other physical methods.

Physical Therapy
The treatment of a Sickness or an Injury by a Health Care Practitioner using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living, and alleviating pain.

Physical Therapy also includes massage therapy as part of an approved Physical Therapy regimen.

Plan
The coverage provided under this Certificate, as determined by pairing the health insurance coverage benefits with an applicable Cost-Sharing structure, Health Care Provider Network, and Service Area.

Plan Year or **Policy Year**
The 12-month period beginning on the Policy's Effective Date (as shown on the Group Major Medical Policy), or on the anniversary of such date of any year while coverage is in force, and ending on the date immediately preceding the anniversary date of the following year.

[Applicable Cost-Sharing amounts and coverage limitations (including, but not limited to, any Deductible and Out-of-Pocket Limit), accumulate, and reset, on a [Plan Year][Calendar Year] basis, as shown on the Benefit Summary.]

Policy
The Group Major Medical Policy issued by Us to the Policyholder that provides benefits for medical or surgical expenses Incurred by Covered Persons as a result of Injury or Sickness.

Policyholder
The employer or entity to which the Policy is issued. The Policyholder has applied for and agreed to the terms and conditions of the Policy.

Prescription Card Service Administrator (PCSA)
An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.

Prescription Drug
Any medication that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States.

2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws.

Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or “Rx Only” on the manufacturer’s label, or similar wording as designated by the FDA.

Prescription Maintenance Drugs
Prescription Drugs that are:

1. Taken regularly to treat a chronic health condition.

2. Covered under the Outpatient Prescription Drug Benefits section.

3. Approved by Us for coverage under the 90-Day Prescription Drug Provider provision in the Outpatient Prescription Drug Benefits section.

Prescription Order
The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill.

2. Insulin, or insulin derivatives, only by prescription.

3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:

    a. Disposable insulin syringes and needles.
    b. Disposable blood/urine/glucose/acetone testing agents or lancets.

Primary Care Practitioner
A Health Care Practitioner whose practice predominantly includes pediatrics, internal medicine, family practice, general practice, or obstetrics/gynecology. A Health Care Practitioner who primarily treats Behavioral Health or Substance Abuse disorders is also considered a Primary Care Practitioner.

Qualified Treatment Plan (QTP)
The plan(s) of treatment using evidence-based therapy and/or clinical procedures. The treatment plan(s) must be prescribed by a Health Care Practitioner or designed by a psychologist and approved by Us before any services will be covered under this Policy.

If there are multiple QTPs or multiple components within a QTP, all services must be coordinated to ensure efficacy of care and non-duplication of treatment. Multiple QTPs or multiple components within a QTP will be reviewed, and may be approved or disapproved independently of each other.

QTP Criteria
- The QTP must describe the Covered Person’s impairments to be treated and the level of severity;
- The QTP must outline measurable goals and respective timeframes and benchmarks for meeting those goals;

- The QTP must designate the type of services and number of hours to be rendered as treatment for the patient;
- The QTP must designate the required interaction and number of hours to be rendered by the parent(s)/guardian(s) of the patient;
- The QTP must incorporate evidence-based behavioral therapy not to include Experimental or Investigational Services;
- The QTP must provide treatment that is appropriate to the clinical situation and age of the Covered Person;
- The QTP must designate the appropriate frequency at which progress will be evaluated and reported; and,
- The QTP must outline treatment discharge criteria.

The QTP must be submitted to Us for review and approval before benefits will be authorized. We will also perform an initial review of progress under the plan within the first 90-days, and subsequent periodic review of progress. You or the provider of services must provide additional documentation as is required by Us as part of this review and to validate the QTP requirements above have been met, and continue to be met as part of ongoing treatment. Failure to provide such documentation will result in the denial of benefits. Subsequent authorization for additional treatment may require revision to the plan or frequency of care based on Our Medical Necessity review, or may require that a revised QTP be submitted before additional benefits are considered.

Reconstructive Surgery
A surgery:

1. To restore function for conditions resulting from or related to an Injury.

2. That is incidental to, or follows surgery resulting from or related to, trauma, infection, or other diseases of the involved part, if the trauma, infection, or other diseases occurred or had their onset while the Covered Person was covered under this Certificate.

3. Because of congenital illness or anomaly of a Covered Dependent child born while this Certificate is in force, which resulted in a functional defect.

4. That reconstructs the breast on which the mastectomy has been performed and the other breast to produce a symmetrical appearance. Surgery includes prostheses and physical complications, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Rehabilitative Services
Specialized treatment for a Sickness or an Injury, which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.

2. Is designed to improve the patient’s function and independence.

3. Is under the direction of an appropriately license Health Care Practitioner.

4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

Routine Patient Costs
Covered Charges associated with participation in an Approved Clinical Trial. Routine Patient Costs do not include:

1. The investigational item, device, or service, itself.

2. Treatment, services, and supplies that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person.

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

Service Area
The geographic area, as defined by Us, served by the Health Care Provider Network. Contact the Network Manager to determine the precise geographic area serviced by Participating Providers. The Service Area is subject to change at any time without notice.

Sickness
A disease or illness of a Covered Person. Sickness includes Behavioral Health and Substance Abuse disorders.

Sickness does not include a family history of a disease or illness, or a predisposition for the development of a future disease or illness.

Single Plan
A Certificate covering only the Certificate Holder.

Skilled Nursing Facility
A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility must meet all of the following requirements:

1. Be licensed by the state in which services are rendered and accredited by one of the following to provide skilled nursing services:

    a. The Joint Commission (TJC).
    b. Commission on Accreditation of Rehabilitation Facilities (CARF).

2. Be staffed by an on call physician 24 hours per day.

3. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.

4. Maintain daily clinical records.

5. Not primarily be a place for rest, for the aged, for Custodial Care, or provide care for Behavioral Health or Substance Abuse, although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care, which would not be covered under this Certificate.

Small Group Health Plan or **Large Group Health Plan**

Based on the number of Employees employed by the Policyholder, Your coverage may be governed in part by state law as a Small Group Health Plan or Large Group Health Plan.

Special Enrollment Period
A period of time during which eligible Employees may apply for coverage under this Plan for themselves and their eligible Dependents without being considered a Late Entrant. A Special Enrollment Period will be granted and commence:

1. On the day of the Certificate Holder's marriage.

2. On the day the Certificate Holder acquires a Dependent child through birth, marriage, adoption, placement for adoption, or legal guardianship.

3. On the day a court orders coverage to be provided under this Certificate for a Certificate Holder's Dependent.

4. On the day after the Employee terminates coverage under another group health plan or other health insurance coverage if:

    a. The Employee and/or Dependents were covered by Creditable Coverage, when they were first eligible to apply for coverage under this Plan, or during the last open enrollment period; and
    b. The Employee previously waived coverage, in writing, at the time they were first eligible to apply for coverage under this Plan, because of being covered by another group health plan or other health insurance coverage; and
    c. The Creditable Coverage described in item 4a above:
        i. Was under either the Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation provision, and the period for which coverage could be continued had been exhausted; or
        ii. Was lost as a result of loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in the number of qualifying hours of employment, termination of the Plan, or termination of employer contributions toward the coverage.

5. On the day after the Employee and/or Dependents terminate coverage under a Medicaid plan (under Title XIX of the Social Security Act) or under a state child health plan (under Title XXI of the Social Security Act) if:

    a. The Employee and/or Dependents were covered by a Medicaid plan or state child health plan when they were first eligible to apply for coverage under this Plan, or during the last open enrollment period; and
    b. The Employee previously waived coverage under this Plan because of being covered by a Medicaid plan or state child health plan; and
    c. The coverage of the Employee and/or Dependents under such Medicaid plan or state child health plan is terminated as a result of loss of eligibility for such coverage, and the Employee requests coverage under this Plan no later than 60 days after the date of termination of such coverage; or
    d. The Employee and/or Dependents become eligible for assistance, with respect to coverage under this Plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under, or in relation to, such a plan), and the Employee requests coverage under this Plan no

later than 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

Specialized Medical Care Plan
A special arrangement by which We may provide benefits to the Covered Person to assist with treating, controlling, or managing certain conditions or encouraging healthy outcomes by improving the quality of life while Medically Necessary treatment is received.

Specialized Medical Care Program
Our program and guidelines providing Specialized Medical Care Plans to Covered Persons.

Specialty Care Provider
A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties or who is designated by the Network Manager as a Specialty Care Provider. A Specialty Care Provider cannot be a Primary Care Practitioner.

Specialty Pharmaceuticals
Drugs that are identified by Us on the Benefit Summary or in the Drug List as Specialty Pharmaceuticals. These types of Prescription Drugs may include:

1. Drugs used to treat rare or certain chronic diseases.
2. Drugs that have a highly targeted, cellular mechanism of action.
3. Drugs that may require injection or other parenteral or unique method of administration.
4. Drugs that may require special administration and monitoring.
5. Drugs that are regularly supplied by Designated Specialty Pharmacy Providers.

Specialty Pharmacy Program
Program(s) created and/or administered by Us, or by one or more of Our Designated Specialty Pharmacy Providers, to manage the effective distribution of Specialty Pharmaceuticals and the treatment, services, and supplies related to such drugs. These programs will include, but are not limited to, pre-authorization requirements, patient and Pharmacy audits, ongoing review for continued Medical Necessity, and supply limitations of 7 days for the first treatment under the program and 30 days for subsequent treatments, or as otherwise authorized by Our designee or Us.

Stabilize or Stabilized or Stabilization
With respect to an Emergency medical condition requiring Emergency Treatment or Emergency Confinement, 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 Covered Person from a facility (or, with respect to a pregnant woman, to deliver, including the placenta). For purposes of this Policy, Stabilization includes services provided during an observation stay when such observation is necessary to determine that the condition is no longer an Emergency medical condition.

Speech and Hearing Disorders
Disorders resulting in loss or impairment of speech or hearing that includes communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental

disabilities or delays, or other causes of organic or non-organic etiology and whether or not the afflicted had the capacity for speech, language or hearing prior.

Necessary care and treatment for such disorders includes services to identify, asses, diagnose, and consult about the need for treatment and to evaluate and monitor treatment's effectiveness.

Speech Therapy
The treatment of a Sickness or an Injury by a Health Care Practitioner using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

Subacute Medical Care
A short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that:

1. Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and

2. Does not require intensive diagnostic and/or invasive procedures; and

3. Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Subacute Rehabilitation Facility
A facility that provides Subacute Medical Care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by one of the following to provide Subacute Medical Care for Rehabilitative Services:

    a. The Joint Commission (TJC).
    b. Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).
    c. Commission on Accreditation of Rehabilitation Facilities (CARF).

2. Be staffed by an on call physician 24 hours per day.

3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

4. Not primarily provide care for Behavioral Health or Substance Abuse, although these services may be provided in a distinct section of the same physical facility.

    The facility may also provide extended care or Custodial Care, which would not be covered under this Plan.

Substance Abuse
Abuse of, addiction to, or dependence on drugs, chemicals, or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us.

Surgical Assistant

A Health Care Practitioner who is licensed to assist at surgery in the state and credentialed at the facility where the procedure is performed, but who is not qualified by licensure, training, and credentialing to perform the procedure as a primary surgeon at that facility.

Telehealth Service
The delivery of health care by a Health Care Practitioner at one location to a patient at a different location via the use of electronic information and telecommunications technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a Covered Person (virtual visit). A Telehealth Service is provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology.

A communication between a Health Care Practitioner and a patient that consists solely of electronic mail (email) or a facsimile transmission is not considered Telehealth Service. A communication between licensed Health Care Practitioners that consists solely of a telephone conversation, an email, or a facsimile transmission is not a Telehealth Service.

Telemedicine Service
A health care service delivered by a physician licensed in this state or by a health professional acting under the delegation and supervision of a physician licensed in this state and acting within the scope of such provider's license, to a Covered Person at a different physical location than the physician or health professional using telecommunications or information technology.

Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction
TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing:

1. Clicking and/or difficulties in opening and closing the mouth.

2. Pain or swelling.

3. Complications including arthritis, dislocation, and bite problems of the jaw.

Total Disability or **Totally Disabled**
As a result of Sickness or Injury, You, or Your spouse, is unable to perform the material and substantial duties of the Covered Person's occupation for a period of at least 12 months.. We will not consider retired individuals and homemakers unable to perform an occupation solely because they are unemployed; a determination will be made based on being unable to engage in the normal and customary activities of a person, of the same age and gender, in good health.

Urgent Care
Treatment or services provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and

2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

Urgent Care Facility
A facility that is attached to a Hospital, but separate from the Emergency Room, or a separate

facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered an Urgent Care Facility, even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.

2. Be staffed by an on duty physician during operating hours.

We, Us, Our, and **Our Company**
National Health Insurance Company or its Administrator.

You, Your, and **Yours**
The Certificate Holder. The Certificate Holder is identified on the web portal as the subscriber.