

# CELTIC INSURANCE COMPANY

Home Office: 233 South Wacker Drive, Chicago, Illinois 60606-6393  
1-800-477-7870

## Major Medical Expense Insurance Policy

In this *policy*, "you" or "your" will refer to the *covered person* named on the Schedule of Benefits, and "we," "our," or "us" will refer to Celtic Insurance Company.

### AGREEMENT AND CONSIDERATION

We issued this *policy* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *policy*. We will pay benefits to *you*, the *covered person*, for covered *loss* due to *illness* or bodily *injury* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

### GUARANTEED RENEWABLE

You may keep this *policy* in force by timely payment of the required premiums. However, we may refuse renewal if: (1) we refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, we will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *covered persons*, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums.

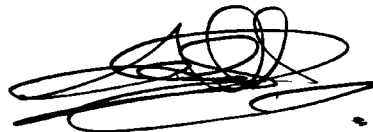
At least 45 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. We will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, we will not restrict coverage already in force.

**As a cost containment feature, this policy contains prior authorization requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.**

### TEN DAY RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the effective date.

Celtic Insurance Company



Anand Shukla  
SVP, Individual Health – Celtic Insurance Company

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## DEFINITIONS

In this policy, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this policy:

***Acute rehabilitation*** means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, *rehabilitation facility*, or *extended care facility*.

***Adverse benefit determination*** means:

1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment in whole or in part for a benefit, including:
  - a. Deductible credits; coinsurance; or other cost sharing requirements;
  - b. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
  - c. A benefit resulting from the application of any utilization review;
  - d. A covered benefit that is otherwise denied as not medically necessary or appropriate;
  - e. A covered benefit that is otherwise denied as experimental or investigational;
2. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
3. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.

***Allogeneic bone marrow transplant*** or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

***Approved Clinical Trial*** means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by

1. an institutional review board that complies with 45 CFR Part 46; and
2. one or more of the following:
  - a) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;
  - b) the United States Department of Health and Human Services, United States Food and Drug Administration;
  - c) the United States Department of Defense;
  - d) the United States Department of Veterans Affairs; or
  - e) a nongovernmental research entity abiding by current National Institutes of Health guidelines.

***Autism Spectrum Disorder*** means pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the DSM of Mental Disorders-IV-TR, as amended or reissued from time to time.

**Autologous bone marrow transplant** or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

**Bereavement counseling** means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

**Calendar Year** is the period beginning on the initial effective date of this *policy* and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

**Center of Excellence** means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

**Coinsurance** is the percentage of *covered expenses* that must be paid by *you* after the *deductible*. This percentage is shown on the Schedule of Benefits.

**Coinsurance percentage** means the percentage of *covered expenses* that are payable by *us*.

**Complaint** means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

**Complications of pregnancy** means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy; and
2. An *emergency caesarean section* or a *non-elective caesarean section*.

**Continuous loss** means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be based on generally accepted current medical practice.

**Cosmetic treatment** means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

**Covered expense** means an expense that is:

1. Incurred while *your* or *your dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

**Covered person** means *you*, *your* lawful spouse and each *eligible child*:

1. Named in the application; or
2. Whom *we* agree in writing to add as a *covered person*.

**Custodial Care** is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

**Deductible amount** means the amount of *covered expenses*, shown in the *Schedule of Benefits*, that must actually be paid during any *calendar year* before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. For family coverage, the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses* but that amount must be paid before benefits are payable for any *covered person*.

**Dental expenses** means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

**Dependent** means *your* lawful spouse and/or an *eligible child*.

**Durable medical equipment** means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

**Effective date** means the applicable date a *covered person* becomes insured for *illness* or *injury*. The applicable *effective date* is shown:

1. In the Schedule of Benefits of this *policy* for initial *covered persons*; and
2. On the rider adding any new *covered person*.

**Eligible child** means *your* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

**Eligible expense** means a *covered expense* as determined below.

When a *covered expense*, excluding Transplant Benefits, is received, the *eligible expense* is determined based on the lesser of/ the first of the following rules that can be applied in the order shown below:

1. The fee that has been negotiated with the provider;
2. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area;
3. The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
4. The fee charged by the provider for the services; or
5. A fee schedule that *we* develop.

**Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain which requires immediate no later than 24 hours after onset medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**Expedited grievance** means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function;
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

**Experimental or investigational treatment** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight;
2. An *unproven service*;
3. Subject to *USFDA* approval, and:
  - a. It does not have *USFDA* approval;

- b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
  - c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
    - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
    - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
    - iii. Not an *unproven service*; or
  - d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *covered person*.
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

***Extended care facility*** means an institution, or a distinct part of an institution, that:

- 1. Is licensed as a *hospital, extended care facility, or rehabilitation facility* by the state in which it operates;
- 2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
- 3. Maintains a daily record on each patient;
- 4. Has an effective utilization review plan;
- 5. Provides each patient with a planned program of observation prescribed by a *physician*; and
- 6. Provides each patient with active treatment of an *illness or injury*, in accordance with existing standards of medical practice for that condition.

*Extended care facility* does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care, nursing care, or for care of mental disorders* or the mentally incompetent.

***Generally accepted standards of medical practice*** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

***Grievance*** means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, an claimant including any of the following:

- 1. Provision of services;
- 2. Determination to reform or rescind a policy;

3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
4. Claims practices.

**Habilitation** means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

**Home health aide services** means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person*.

**Home health care** means care or treatment of an *illness* or *injury* at the *covered person's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

**Home health care agency** means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician*, in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care*.

**Hospice** means an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital*, *hospital-related institution*, *home health care agency*, mental health facility, *extended care facility*, or any other licensed health care institution;
3. Provides care for the *terminally ill*; and
4. Is licensed by the state in which it operates.

**Hospice care program** means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family*.

**Hospital** means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and



6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility*, or *residential treatment facility*, halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

**Illness** means a sickness, disease, or disorder of a *covered person*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

**Immediate family** means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

**Injury** means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

**Inpatient** means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

**Intensive care unit** means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

**Intensive day rehabilitation** means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

**Loss** means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

**Listed transplant** means one of the following procedures and no others:

1. Heart transplants;
2. Lung transplants;
3. Heart/lung transplants;
4. Kidney transplants;
5. Liver transplants;
6. Pancreas transplants;
7. Bone marrow transplants for the following conditions:
  - a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma;
  - b. *BMT* or *ABMT* for Hodgkin's Lymphoma;
  - c. *BMT* for Severe Aplastic Anemia;
  - d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia;

- e. *BMT* for Chronic Myelogenous Leukemia;
- f. *ABMT* for Testicular Cancer;
- g. *BMT* for Severe Combined Immunodeficiency;
- h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma;
- i. *BMT* for Myelodysplastic Syndrome;
- j. *BMT* for Wiskott-Aldrich Syndrome;
- k. *BMT* for Thalassemia Major;
- l. *BMT* or *ABMT* for Multiple Myeloma;
- m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma and glioma;
- n. *BMT* for Fanconi's anemia;
- o. *BMT* for malignant histiocytic disorders; and
- p. *BMT* for juvenile.

***Loss of Minimum essential coverage*** means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual, and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals as described in § [54.9802-1\(d\)](#) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

***Managed drug limitations*** means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

**Manipulative Therapy** means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofascial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

**Maximum therapeutic benefit** means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

**Medical practitioner** means a *physician*, nurse anesthetist, physician's assistant, physical therapist, midwife, or any other health care provider, who is licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

**Medically necessary** or **medical necessity** means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *covered person's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *covered person*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible expenses*.

**Medically stabilized** means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

**Medicare opt-out practitioner** means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

**Medicare participating practitioner** means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

**Mental disorder** is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

**Necessary medical supplies** means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;

2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

**Necessary medical supplies** do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

**Non-elective caesarean section** means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

**Other plan** means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

**Out-of-pocket expenses** means those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

**Outpatient surgical facility** means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

**Pain management program** means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

**Period of extended loss** means a period of consecutive days:

1. Beginning with the first day on which a *covered person* is a *hospital inpatient*; and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient*.

**Physician** means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

**Policy** when *italicized*, means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

**Post-service claim** means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

**Pre-service claim** means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

**Pregnancy** means the physical condition of being pregnant, but does not include *complications of pregnancy*.

**Prescription drug** means any medicinal substance whose label is required to bear the legend "RX only."

**Prescription order** means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

**Proof of loss** means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

**Reconstructive surgery** means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

**Rehabilitation** means care for restoration including by education or training of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation, sub-acute rehabilitation, or intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

**Rehabilitation facility** means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

**Rehabilitation facility** does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care*, nursing care, or for care of the mentally incompetent.

**Rehabilitation medical practitioner** means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

**Rehabilitation therapy** means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

**Rescission** of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

**Residence** means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address, not a P.O. Box, shown on *your* United States income

tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

**Residential treatment facility** means a facility that provides, with or without charge sleeping accommodations, and:

1. Is not a *hospital, extended care facility, or rehabilitation facility*; or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

**Respite care** means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

**Spouse** means *your* lawful wife or husband.

**Sub-acute rehabilitation** means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital, rehabilitation facility, or extended care facility*.

**Substance abuse** means alcohol, drug or chemical abuse, overuse, or dependency.

**Surgery** or **surgical procedure** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *covered person's illness or injury* by manual or instrumental operations, performed by a *physician* while the *covered person* is under *general or local anesthesia*.

**Surveillance tests for ovarian cancer** means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

**Terminal illness counseling** means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

**Terminally ill** means a *physician* has given a prognosis that a *covered person* has six months or less to live.

**Third party** means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness or injury*. The term "*third party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third party*" will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

**Tobacco use or use of tobacco** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months

immediately preceding the date application for this *policy* was completed by the *covered person*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

***Unproven service(s)*** means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. "*Well-conducted randomized controlled trials*" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
2. "*Well-conducted cohort studies*" means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

***Urgent care center*** means a facility, not including a *hospital emergency room* or a *physician's office*, that provides treatment or services that are required:

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

## DEPENDENT COVERAGE

### Dependent Eligibility

Your *dependents* become eligible for insurance on the latter of:

1. The date *you* became insured under this *policy*; or
2. The first day of the first full calendar month after the date of becoming *your dependent*.

### Effective Date For Initial Dependents

The *effective date* for your initial *dependents*, if any, is shown on the Schedule of Benefits. Only *dependents* included in the application for this *policy* will be covered on your *effective date*.

### Adding A Newborn Child

A child born to a *covered person* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within 60 days of the child's birth.

### Adding An Adopted Child

An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement*, unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within 60 days of the date of *placement*.

As used in this provision, "*placement*" means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

### Adding Other Dependents

If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.



## ONGOING ELIGIBILITY

### For All Covered Persons

A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*; or
2. The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.

### For Dependents

A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which we receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

### Open Enrollment

There will be an open enrollment period for coverage. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. *Individuals* who enroll prior to December 15, 2013 will have an effective date of coverage on January 1, 2014. *Individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. *Individuals* that enroll between the sixteenth and last day of the month between December 2013 and March 31, 2014, will have a coverage effective date of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Individuals* who enroll prior to December 7, 2014 will have an effective date of coverage on January 1<sup>st</sup> of the following year.

Starting in 2014, we will send written annual open enrollment notification to each *covered person* no earlier than September 1<sup>st</sup>, and no later than September 30<sup>th</sup>.

### Special And Limited Enrollment

An *individual* has 60 days to enroll as a result of one of the following events:

1. An *individual* or *dependent* loses minimum essential coverage;
2. An *individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an agent;

5. An *individual* or enrollee gains access to new health plans as a result of a permanent move;
6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or
7. With respect to individuals enrolled in non-calendar year health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

# PREMIUMS

## **Premium Payment**

Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

## **Grace Period**

After the first premium is paid, a grace period of 31 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If payment of premium is not received within the grace period, coverage will be terminated as of the premium due date.

## **Misstatement Of Age**

If a *covered person's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

## **Change Or Misstatement Of Residence**

If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

## **Misstatement Of Tobacco Use**

The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered person's* use of tobacco has been misstated on the *covered person's* application for coverage under this *policy*, *we* have the right to re-rate the policy back to the original effective date.

## **Billing/Administrative Fees**

Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a \$20 fee for any check or automatic payment deduction that is returned unpaid.

# MAJOR MEDICAL EXPENSE BENEFITS

## **Deductible**

The *deductible amount* means the amount of *covered expenses* that must be paid by all *covered persons* before any benefits are payable.

## **Coinsurance Percentage**

We will pay the applicable *coinsurance percentage* in excess of the applicable deductible for a service or supply that:

1. Qualifies as a *covered expense* under one or more benefit provisions; and
2. Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*; and
2. A determination of *eligible expenses*.

## **Coverage Under Other Policy Provisions**

Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy*.

## **Ambulance Service Benefits**

*Covered expenses* will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *covered person's illness or injury*; or
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses, injuries, congenital birth defects, or complications of premature birth* that require that level of care.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
2. Those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance;
3. Air ambulance:
  - a. Outside of the 50 United States and the District of Columbia;
  - b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
  - c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or

4. Ambulance services provided for a *covered person's* comfort or convenience.

### **Mental Health and Substance Abuse Expense Benefits**

*Covered expenses* for mental health and substance abuse are included on a non-discriminatory basis for all *covered persons* for the diagnosis and *medically necessary* and active treatment of mental, emotional, and substance use disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. *Deductible* and treatment limits for behavioral health expense benefits will be applied in the same manner as physical health service benefits.

*Covered expenses* are included on a non-discriminatory basis for individuals seeking diagnosis and treatment for mental health disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation allowed by the state.

Inpatient, intermediate and outpatient mental health and substance abuse service expenses are covered, if *medically necessary* and may be subject to prior authorization. See the Prior Authorization section for more information regarding services that require prior authorization and see the Schedule of Benefits for specific benefit, day or visit limits, if any. Medication management visits do not require prior authorization.

Inpatient mental health and substance abuse *covered expenses* include the following: 24 hour services, delivered in a psychiatric unit of a licensed general hospital, a psychiatric hospital, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate mental health and substance abuse *covered expenses* include the following: Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on *medical necessity*.

Outpatient mental health and substance abuse *covered expenses* include the following: Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed *hospital*, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community mental health center, a professional office or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist acting within the scope of his/her license.

Other *covered expenses* for mental health and substance abuse include:

1. Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and *autism*;
2. For children and adolescents under the age of 19:
  - a. Treatment of non-biologically-based mental, behavioral, or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19; and

- b. Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.
3. Adult substance abuse residential treatment;
4. Clinically managed detoxification services in a substance abuse facility;
5. Partial hospitalization;
6. Intensive Outpatient Programs (IOP).

### **Autism Spectrum Disorders Services**

Coverage is provided for *medically necessary* services and supplies for members who are under 21 years of age for the diagnosis and treatment of autism spectrum disorders.

Coverage is provided for the following:

- Habilitative or rehabilitative care, including applied behavior analysis, counseling and treatment programs necessary to develop, maintain, or restore the functioning of a *covered person*;
- Therapeutic care as identified in a treatment plan developed following a comprehensive evaluation, including behavioral, speech, occupational, and physical therapies.

Treatment may be provided by the following providers:

- A licensed physician
- A psychologist
- An advanced nurse practitioner
- An *autism spectrum service* provider or a provider supervised by an *autism spectrum service* provider;
- Any other provider type that is licensed to practice where the care is provided and is providing a service within the scope of that license.

### **Neurodevelopmental Therapy**

Coverage is provided for the treatment of neurodevelopmental disabilities for members under the age of 7, or for members under the age of 21 who are diagnosed with *autism spectrum disorder*. The following inpatient and outpatient neurodevelopmental therapy services must be *medically necessary* to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy.

- Inpatient Care Benefits for inpatient facility and professional care are provided up to 30 days per *covered person* each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility, and will only be covered when services can't be done in a less intensive setting.
- Outpatient Care Benefits for outpatient care are subject to the following provisions:
  1. The *covered person* cannot be confined in a hospital or other medical facility.
  2. The therapy must be part of a formal written treatment plan prescribed by a physician.
  3. Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational or speech therapist.

When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services, up to a maximum benefit of 45 visits per *covered person* each calendar year. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

### **Habilitation, Rehabilitation And Extended Care Facility Expense Benefits**

*Covered expenses* include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
  - a. Daily room and board and nursing services;
  - b. Diagnostic testing; and
  - c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
3. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon occurrence of any of the following:

1. The *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Exclusion:

No benefits will be paid under these Habilitation, Rehabilitation and Extended Care Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Definition:

As used in this provision, "*provider facility*" means a *hospital*, *rehabilitation facility*, or *extended care facility*.

### **Home Health Care Expense Benefits**

*Covered expenses* for *home health care* are limited to the following charges:

1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an outpatient basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*;
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Necessary medical supplies*; and
7. Rental of the *durable medical equipment* set forth below:
  - a. I.V. stand and I.V. tubing;
  - b. Infusion pump or cassette;
  - c. Portable commode;
  - d. Patient lift;
  - e. Bili-lights, and
  - f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital stay*.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Limitations:

*Covered expenses* for *home health aide services* will be limited to:

1. Seven visits per week; and
2. A calendar year maximum of 130 visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

*Covered expenses* for outpatient private duty registered nurse services will be limited as follows:

1. Outpatient private duty registered nurse services will be limited to a calendar year maximum of 130 visits and
2. Intermittent private duty registered nurse visits are not to exceed 4 hours each.

Exclusion:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care.

### **Hospice Care Expense Benefits**

This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Miscellaneous Medical Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *covered person* is an *inpatient*;
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital*;
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness*;
7. *Terminal illness counseling* of members of the *covered person's immediate family*, and
8. Up to \$250 for *bereavement counseling*.



### Exclusions And Limitations:

Any exclusion or limitation contained in the *policy* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program*; or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to 180 days in a *covered person's* lifetime. For each day the *covered person* is confined in a *hospice*, benefits for room and board will not exceed for a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

### Electronic Visits

Coverage will be provided for electronic visits (e-visits) when all the requirements below are met. *You* pay the same cost-shares for e-visits as you do for in-person visits to the doctor's office. This benefit is only provided when three things are true:

- *We* have approved the *physician* for e-visits. Not all *physicians* have agreed to or have the software capabilities to provide e-visits.
- The *covered person* has previously been treated in the approved *physician's* office and has established a patient-physician relationship with that *physician*.
- The e-visit is *medically necessary* for a covered illness or injury.

An e-visit is a structured, secure online consultation between the approved physician and the *covered person*. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in their practice.

### Miscellaneous Medical Expense Benefits

Medical *covered expenses* are limited to charges:

1. Made by a *hospital* for:
  - a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate;
  - b. Daily room and board and nursing services while confined in an *intensive care unit*.
  - c. *Inpatient* use of an operating, treatment, or recovery room;
  - d. Outpatient use of an operating, treatment, or recovery room for *surgery*;
  - e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients*; and
  - f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies;
3. Made by a *physician* for professional services, including *surgery*;
4. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure*;
5. For the professional services of a *medical practitioner*;
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.

7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included;
8. For chemotherapy and radiation therapy or treatment;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For *dental expenses* when a *covered person* suffers an *injury*, after the *covered person's effective date* of coverage, that results in:
  - a. Damage to his or her natural teeth; and
  - b. Expenses are incurred within twelve months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within twelve months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing;
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the Schedule of Benefits for benefit levels or additional limits;
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. For acupuncture treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits;
15. For phenylketonuria treatment charges which are administered under the supervision of a *physician*. Coverage includes testing, diagnosis and dietary formulas which are *medically necessary* for the therapeutic treatment of phenylketonuria;
16. For *medically necessary* services and supplies used in the treatment of diabetes. *Covered expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;
17. For *medically necessary manipulative therapy* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered expenses* are subject to all other terms and conditions of the *policy*, including deductible and *coinsurance percentage* provisions;
18. An annual pap smear cancer screening test for a person who is 18 or more years of age to test for cervical cancer;
19. For Health Management, benefits are covered for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are diabetes health education, asthma education, pain management, and childbirth and newborn parenting training. Benefits are also provided for outpatient nicotine dependency programs;
20. Coverage for outpatient nutritional therapy services to manage a *covered person's* covered condition, illness or injury, including services to manage diabetes or eating disorders. Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits;
21. For maternity care of the primary *covered person, spouse, or eligible child*: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and

radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy*, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;

22. Annual prostate cancer screening tests for a *covered person* who is:
  - a. At least 35 years of age but less than 40 years of age and the person is in a high risk group; in this paragraph, "high risk" means a person who is an African-American or who has a family history of prostate cancer; or
  - b. 40 or more years of age;
23. Baseline mammograms for a *covered person* who is at least 35 years of age but less than 40 years of age; Bi-annual mammograms for a *covered person* who is at least 40 years of age but less than 50 years of age; Annual mammograms for a *covered person* who is at least 50 years of age; and mammograms at any age for a *covered person* with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a *physician*.
24. For colorectal cancer screenings as specified in the American Cancer Society guidelines for colorectal cancer screenings at a frequency identified by the American Cancer Society guidelines for colorectal cancer. Coverage will be provided for a *covered person* who is (1) at least 50 years of age; or (2) less than 50 years of age but at high risk for colorectal cancer based on:
  - a. family history;
  - b. prior experience of cancer or precursor neoplastic polyps;
  - c. a history of a chronic digestive disease condition, including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis;
  - d. the presence of any appropriate recognized gene markers for colorectal cancer; or
  - e. other predisposing factors; and
25. For the following types of tissue transplants:
  - a. Cornea transplants;
  - b. Artery or vein grafts;
  - c. Heart valve grafts;
  - d. Prosthetic tissue replacement, including joint replacements; and
  - e. Implantable prosthetic lenses, in connection with cataracts.

### **Miscellaneous Outpatient Medical Services and Supplies Expense Benefits**

*Covered expenses* for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*;
2. For one pair of foot orthotics per *covered person*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;

8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;
9. For occupational therapy following a covered treatment for traumatic hand injuries; and
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits; and
11. Sales tax is covered for all covered medical equipment and supplies.

### **Clinical Trials for Cancer and Other Life-Threatening Illnesses**

*Covered expenses* for the routine patient care costs incurred by a *covered person* enrolled in an *approved clinical trial* related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the *covered person's physician* determines that:

1. there is no clearly superior noninvestigational treatment alternative; and
2. available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any noninvestigational alternative.

*Covered expenses* include the costs of:

1. prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an *approved clinical trial*;
3. items or services necessary to provide an investigational item or service;
4. the diagnosis or treatment of complications;
5. a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
6. services necessary to administer a drug or device under evaluation in the clinical trial; and
7. transportation for the patient that is primarily for and essential to the medical care.

*Covered expenses* do not include:

1. a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;
2. housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. an item or service excluded from coverage under the patient's health care insurance plan; and
5. an item or service paid for or customarily paid for through grants or other funding.

The coverage required by this section is subject to the standard policy provisions applicable to other benefits, including deductible and coinsurance.

### **Outpatient Prescription Drug Expense Benefits**

*Covered expenses* in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug*; and
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *physician*.

#### Notice And Proof Of Loss:

In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders*, a notice of claim and *proof of loss* must be submitted directly to us.

#### Exclusions And Limitations:

No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For immunization agents;
3. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed;
4. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. Due to a *covered person's* addiction to, or dependency on foods;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For a *prescription drug* that contains an active ingredient(s) that is/are:
  - a. Available in and *therapeutically equivalent* to another covered *prescription drug*; or
  - b. A modified version of and *therapeutically equivalent* to another covered *prescription drug*. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph;
11. For more than a 34-day supply when dispensed in any one prescription or refill, a 90-day supply when dispensed by mail order;
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription; and
13. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

### **Pediatric Oral Expense Benefits**

Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Diagnostic, preventive and restorative care;
2. Oral surgery and reconstruction;
3. Endodontic and periodontic care;
4. Crown and fixed bridge;
5. Removable prosthetics; and
6. *Medically necessary* orthodontia.

Visit limitations are as follows:

1. One diagnostic exam every six months, beginning before age one;
2. Bitewing x-rays twice per year;
3. Panoramic x-rays once every three years;
4. Prophylaxis every six months beginning at age six months;
5. Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
6. Every two years for the same restoration;
7. Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
8. Root canals on baby primary posterior teeth only; Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
9. Periodontal scaling and root planing once per quadrant in a two-year period for ages 13 and older, with prior authorization;
10. Periodontal maintenance once per quadrant in a twelve-month period for ages 13 and older, with prior authorization;
11. Stainless steel crowns for permanent posterior teeth once every three years;
12. Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
13. Space maintainers ;
14. One resin based partial denture, replaced once within a three-year period;
15. One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date; and
16. Rebasement and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

### **Pediatric Vision Expense Benefits**

Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Routine vision screening, including dilation and with refraction every calendar year, including dilation;
2. One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;
3. One pair of frames every calendar year; and
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

*Covered expenses* do not include:

1. Visual therapy; or
2. Two pair of glasses as a substitute for bifocals.

### **Adult Dental Coverage**

Up to \$1,500 for all covered dental services for each *covered person* during the calendar year. *You* pay a \$50 deductible per person for Class II and Class III services each calendar year.

Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge, are *your* responsibility.

#### Class I Services

The Dental Plan covers 100 percent of the usual, customary and reasonable charges with no deductible for the following Class I services rendered by a dentist (D.D.S. or D.M.D.). Class I services include:

- oral examinations;
- dental X-rays;
- topical fluoride application (painting the surface of the teeth with a fluoride solution); and
- prophylaxis, including cleaning, scaling and polishing.

#### Class II Services

Following the \$50 deductible, the Dental Plan covers 80 percent of the usual, customary and reasonable charges for Class II services. These include:

- fillings of silver amalgam, silicate and plastic restoration;
- repair of dentures and bridges;
- palliative (alleviation of pain) emergency treatment;
- extractions (removal of teeth);
- endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment;
- space maintainers;
- oral surgery, including surgical extractions;
- apicoectomy (surgical removal of a root tip); and
- periodontic services (treatment of the supporting tooth structures).

#### Class III Services

Following the \$50 deductible, the Dental Plan pays up to 50 percent of the usual, customary and reasonable charges for Class III services. These include:

- inlays and onlays;
- crowns;
- bridges, fixed and removable; and
- dentures, full and partial.

### **Dental Services Not Covered**

The Dental plan does not provide benefits for:

- services for congenital deformities or for purposes of improving personal appearance;
- services that the dentist is not licensed to perform;
- charges that are higher than would have been charged if there were no Dental Plan;

- services for dentures, bridges, crowns or other devices started before the effective date of coverage;
- charges made after *your* coverage ends, unless they are for prosthetic devices fitted and ordered while *you* were covered and arriving within 90 days of the coverage end date;
- services rendered after the end of coverage, even if *you* are in the course of an approved treatment plan;
- charges of more than one dentist for the same services in the same visit;
- appliances or restorations necessary to increase vertical dimensions or restore occlusions;
- services for straightening teeth or correcting bite (orthodontics) except for tooth extractions necessary to proceed with orthodontic services;
- a denture replacement made less than five years after the last one was obtained, whether or not it was covered by this Plan;
- replacement costs of a lost or stolen denture if this benefit has been used within the last five years; and
- special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.

With respect to *your* dental services, Celtic has, at its expense, the right to request that *you* obtain an oral examination by a dentist of its choice in order to determine the best course of treatment or to obtain a second opinion.

#### Advance Claim Review

Before beginning treatment for which charges are expected to exceed \$500, ask *your* dentist to file a description of the proposed course of treatment and expected charges with *us*. *We* review the proposal and advise *you* and *your* dentist of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more providers for the treatment of a condition diagnosed by the attending *physician* or dentist as a result of an examination. It commences on the day the provider first renders the service to correct or treat such a condition.

Emergency treatments, oral examinations, prophylaxis, and dental X-rays are considered part of a course of treatment; but *you* may seek these services without advance claim review.

The Plan pays for the least expensive, professionally adequate service. By receiving an advance review, *you* will eliminate the possibility of unexpected claim denials. As part of advance claim review and proof of loss for any claim, *we*, at *our* expense, have the right to require *you* to obtain an oral examination. *You* must furnish to *us* all diagnostic and evaluative material required to establish *your* right to benefits. Evaluative material includes dental X-rays, models, charts and written reports.

In many cases, alternate services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or injury and recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account *your* total oral condition.

Examples of alternative services or supplies for restorative care are:



- gold, baked porcelain restorations, crowns and jackets (If a tooth can be restored with amalgam or like material and *you* and *your* dentist select another type of restoration, *your* benefits are limited to the appropriate charges for amalgam or similar material.); and
- reconstruction. (Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and not covered.)

Examples of alternative services or supplies for prosthodontic care are:

- partial dentures (If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and *you* and *your* dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.);
- complete dentures (If, in the provision of complete denture services, *you* and *your* dentist decide on personalized restorations or specialized techniques, as opposed to standard procedures, covered expenses are limited to appropriate charges for the standard procedures.); and
- replacement of existing dentures. (Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.)

### **Adult Vision Plan Highlights**

- Requires no deductible.
- Covers one complete eye examination, including a required refraction, during any calendar year.
- Pays 80 percent for two lenses during each calendar year.
- Pays 80 percent for one set of frames every two years.

### **Covered Vision and Optical Services**

The Vision Plan pays 80 percent of the usual, customary and reasonable charges for covered expenses. Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge, are *your* responsibility.

*You* pay no deductible under the Vision Plan. *You* are covered for:

- one complete eye examination, including a required refraction, by a legally qualified ophthalmologist or optometrist, during a calendar year;
- lenses, but not more than two during a calendar year;
- frames, but not more than one pair during any two consecutive calendar years.
- contact lenses necessary because of:
  1. cataract surgery;
  2. extreme visual acuity problems that cannot be corrected to at least 20/70 with spectacle lenses.

The maximum lifetime amount payable for necessary contact lenses is \$400. Cosmetic contacts elected in lieu of glasses. These will be covered the same as any other single vision spectacle lenses. This means that *you* must pay the difference between the usual, customary and reasonable cost of normal lenses and contact lenses.

### **Not Covered Vision and Optical Services**

Benefits are not payable for:

- two pairs of glasses in lieu of bifocals;

- medical or surgical treatment of the eyes;
- vision care services or supplies covered under the Medical Plan;
- services or supplies provided under worker's compensation law or any law of similar purpose, whether benefits are payable for all or part of the charges;
- special procedures, such as orthoptics or vision training, or special supplies, such as nonprescription sunglasses and subnormal vision aids;
- antireflective coatings;
- eye examinations required as a condition of employment, under a labor agreement, or government law;
- replacement of lost, stolen, or broken lenses, if this benefit has been used in the current calendar year;
- replacement of lost, stolen, or broken frames if this benefit has been used in the current or prior calendar year;
- duplicate or spare eyeglasses, including lenses and frames; and,
- services or supplies received before coverage begins, including lenses and frames ordered as part of a prior examination.

### **Audio Plan Highlights**

- Pays 80 percent of the usual, customary and reasonable charges.
- Requires no deductibles.
- Allows a maximum benefit of \$800 in a three-year period.

### **Covered Audio Services**

The Audio Plan pays 80 percent of the usual, customary and reasonable charges for the covered expenses. Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge are *your* responsibility.

*You* pay no deductible under the Audio Plan. *You* receive coverage for:

- an otological (ear) examination by a *physician* or surgeon;
- an audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation;
- a hearing aid (monaural or binaural) prescribed as a result of the examination (This includes ear mold(s), hearing aid instrument, initial batteries, cords and other necessary supplementary equipment as well as warranty, and follow-up consultation within 30 days following delivery of the hearing aid.); and
- repairs, servicing or alteration of hearing aid equipment.

The maximum benefit for each person in a three-year period (current and two previous years) is \$800. *You* must provide *us* with written certification from the examining *physician*. This certification should explain that *you* are suffering a hearing loss that may be lessened by the use of a hearing aid.

### **Not Covered Audio Services**

The Audio Plan does not pay for:

- replacement of a hearing aid, for any reason, more than once in a three-year period;
- batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid;
- a hearing aid exceeding the specifications prescribed for correction of hearing loss; and

- expenses incurred after coverage ends, unless *you* order a hearing aid before the termination and receive it within 90 days of the end date.

### **Preventive Care Expense Benefits**

*Covered expenses* are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles and coinsurance provisions under the *policy* when the services are provided by a *network provider*.

Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services. Reasonable medical management techniques may result in the application of deductibles and coinsurance provisions to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles and coinsurance provisions.

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

### **Newborns' And Mothers' Health Protection Act Statement Of Rights**

If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a

physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours.

**Note:** This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

### **Transplant Service Expense Benefits**

Covered expenses for transplant expenses:

If it is determined that a *covered person* is an appropriate candidate for a *listed transplant*, Medical Benefits *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence* and
7. Post transplant follow-up.

Transplant Donor Expenses:

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

1. They would otherwise be considered *covered expenses* under the *policy*;
2. The *covered person* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant*.

Ancillary "Center Of Excellence" Benefits:

A *covered person* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence*:

1. *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow; and
2. We will pay a maximum of \$10,000 per lifetime for the following services:
  - a. Transportation for the *covered person*, any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence*.
  - b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence*. We will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:

No benefits will be paid under these Transplant Expense Benefits for charges:

1. For search and testing in order to locate a suitable donor;
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
3. For *experimental* or *investigative* animal to human transplants;

4. For *experimental* or *investigative* artificial or mechanical devices designed to replace a human organ temporarily or permanently;
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
6. To keep a donor alive for the transplant operation;
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
8. Related to transplants not included under this provision as a *listed transplant*; and
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expenses Benefits:

In addition to the exclusions and limitations specified elsewhere in this section:

1. If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits; and
2. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

# PRIOR AUTHORIZATION

## **Prior Authorization Required**

Some *covered expenses* require prior authorization. The following services or supplies require prior authorization:

1. *Hospital* confinements;
2. *Hospital* confinement as the result of a *medical emergency*;
3. *Hospital* confinement for *psychiatric care*;
4. *Outpatient surgeries* and diagnostic radiological tests;
5. *All inpatient services*;
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled nursing facility* confinements;
9. *Transplants*;
10. Chemotherapy, *specialty drugs* and biotech medications;
11. Periodontal scaling and root planing once per quadrant in a two-year period for ages 13 and older;
12. Periodontal maintenance once per quadrant in a twelve-month period for ages 13 and older; and
13. Metal/porcelain crowns and porcelain crowns on anterior teeth only.

Except for *medical emergencies*, Certification must be obtained before services are rendered or expenses are *incurred*.

## **How To Obtain Prior Authorization**

To obtain prior authorization contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person*.

Prior Authorization requests will be decided within 72 hours after receiving the request for prior authorization for non-emergency situations and 24 hours after receiving the request for prior authorization for emergency services. A denial, if given, will be decided by a licensed health care provider.

## **Failure To Obtain Prior Authorization**

Failure to comply with the prior authorization requirements will result in benefits being reduced.

There is a penalty if treatment is not authorized prior to service. The penalty is a 20% reduction of the eligible expenses for all charges related to the treatment. The penalty applies to all otherwise eligible expenses that are:

- Incurred for treatment without prior authorization;
- Incurred during additional *hospital* days without prior authorization; or
- Determined to be inappropriately authorized following a retrospective review, or inappropriately authorized due to misrepresentation of facts or false statements.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency*. However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior authorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the prior authorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider.

**Prior Authorization Does Not Guarantee Benefits**

*Our* authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy*.

**Requests For Predeterminations**

*You* may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us*;
2. The medical expense has already been paid by someone else; and
3. Another party is responsible for payment of the medical expense.

*We* will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss*.

## GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *covered person's immediate family; and*
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses*.

Even if not specifically excluded by this *policy*, no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician*; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Expense Benefits provision.

*Covered expenses* will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense*;
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For breast reduction or augmentation, unless in connection with a mastectomy or when *medically necessary*;
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person*, such as sex-change *surgery*;
6. For reversal of sterilization and vasectomies;
7. For abortion unless the life of the mother would be endangered if the fetus were carried to term.
8. For expenses for television, telephone, or expenses for other persons;
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
10. For telephone consultations or for failure to keep a scheduled appointment;
11. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission;
12. For stand-by availability of a *medical practitioner* when no treatment is rendered;
13. For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in an *eligible child* who is a *covered person* ;
15. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
16. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*;
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;



18. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
19. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
20. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services unless expressly provided for by the *policy*;
21. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
22. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
23. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
24. For *experimental or investigational treatment(s) or unproven services*. The fact that an *experimental or investigational treatment or unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment or unproven service* for the treatment of that particular condition;
25. As a result of an *injury or illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
26. As a result of:
  - a. Intentionally self-inflicted bodily harm whether the *covered person* is sane or insane;
  - b. An *injury or illness* caused by any act of declared or undeclared war;
  - c. The *covered person* taking part in a riot; or
  - d. The *covered person's* commission of a felony, whether or not charged;
27. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Medical Benefits;
28. For any *illness or injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*;
29. For or related to surrogate parenting;
30. For or related to treatment of hyperhidrosis (excessive sweating);
31. For fetal reduction surgery;
32. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
33. For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date; and
34. For the following miscellaneous items: artificial Insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating

agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; elective care; sclerotherapy for varicose veins; treatment of spider veins; smoking cessation drugs, programs or services, except where required by federal or state law; and transportation expenses. These miscellaneous items are only covered when specifically described in this *policy*;

35. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.

**Limitation On Benefits For Services Provided By Medicare Opt-Out Practitioners**

Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

# TERMINATION

## Termination Of Policy

All insurance will cease on termination of this *policy*. This *policy* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date *we* receive a request from *you* to terminate this *policy*, or any later date stated in *your* request;
3. The date *we* decline to renew this *policy*, as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan;
5. The date that a *covered person* accepts any direct or indirect contribution or reimbursement through wage adjustment or otherwise, by or on behalf of an employer for any portion of the premium for coverage under this *policy*, or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
6. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move; or
7. The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*.

*We* will refund any premium paid and not earned due to *policy* termination.

If this *policy* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *covered person*; otherwise
2. By the youngest child who is a *covered person*.

This *policy* will be changed to a plan appropriate, to the *covered person(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

## Discontinuance

### 90-Day Notice:

If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

### 180-Day Notice:

If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

### **Portability Of Coverage**

If a person ceases to be a *covered person* due to the fact that the person no longer meets the definition of *dependent* under the *policy*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *policy* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *policy*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. If the original coverage contains a family deductible which must be met by all *covered persons* combined, only those expenses incurred by the *covered person* continuing coverage under the new policy will be applied toward the satisfaction of the *deductible amount* under the new policy.

### **Notification Requirements**

It is the responsibility of *you* or *your* former *dependent* to notify *us* within 31 days of *your* legal divorce or *your dependent's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

### **Continuation of Coverage**

*We* will issue the continuation of coverage:

1. No less than 30 days prior to a *covered person's* 26th birthday; or
2. Within 30 days after the date *we* receive timely notice of *your* legal divorce. *Your* former *dependent* must pay the required premium within 31 days following notice from *us* or the new *policy* will be void from its beginning.

### **Reinstatement**

If (1) a renewal premium is not paid within the time granted the insured for payment, (2) a subsequent acceptance of premium by the insurer or by an agent authorized by the insurer to accept the premium occurs, without requiring in connection therewith an application for reinstatement, and (3) the insurer issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking approval, upon the 45th day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from the accidental injury that may be sustained after the date of reinstatement and loss due to the sickness that may begin more than 10 days after that date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Reinstatement shall not change any provisions of the *policy*.

### **Benefits After Coverage Terminates**

Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries*. However, no benefits are provided if this *policy* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* voluntary or intentional failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*, as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy*. In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss*, but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. *You're* covered under a health plan or contract that provides benefits for *your* confinement or would provide benefits for *your* confinement if coverage under this plan didn't exist; or
3. *You're* discharged from that facility or from any other facility to which you were transferred; or
4. Inpatient care is no longer *medically necessary*; or
5. The maximum benefit for inpatient care in the medical facility has been provided. If the calendar year ends before a calendar year maximum has been reached, the balance is still available for covered inpatient care you receive in the next year. Once it's used up, however, a calendar year maximum benefit won't be renewed; or
6. This plan's annual plan maximum has been provided..

During coverage for a *period of extended loss* or a *continuous loss*, as described above, the terms and conditions of this *policy*, including those stated in the Premiums section of this *policy*, will apply as though insurance had remained in force for that *illness* or *injury*.

## COORDINATION OF BENEFITS

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits.

The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

### DEFINITIONS

A *Plan* is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes: group and non-group insurance 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. 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 Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

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

Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

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 Plans provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by 2 or more 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 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 Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all 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 shall 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 Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

#### **ORDER OF BENEFIT DETERMINATION RULES**

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

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.  
 (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 shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- 1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare *beneficiary* and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
  - 2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
    - b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - i. The Plan covering the Custodial parent;



- ii. The Plan covering the spouse of the Custodial parent;
  - iii. The Plan covering the non-custodial parent; and then
  - iv. The Plan covering the spouse of the non-custodial parent.
- (c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(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 Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

#### **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 Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any 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 shall not apply between that 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 Plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the

purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

#### **FACILITY OF PAYMENT**

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsibility for COB administration] 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. [Organization responsibility for COB administration] 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 [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## REIMBURSEMENT

If a *covered person's illness or injury* is caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *policy* benefits for the *covered person's loss*. We will have the right to be reimbursed to the extent of benefits we paid for the *illness or injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with us in order to obtain information about the *loss* and its cause;
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by us on behalf of a *covered person* in any claim made against any *third party*;
4. That we:
  - a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount we have paid;
  - b. May give notice of that lien to any *third party* or *third party's* agent or representative;
  - c. Will have the right to intervene in any suit or legal action to protect *our* rights;
  - d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
  - e. May assert that subrogation right independently of the *covered person*;
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date, and deliver to us any documents we request that protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so;
8. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness or injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses; and
9. That we may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse us.

Furthermore, as a condition of *our* payment, we may require the *covered person* or the *covered person's* guardian, if the *covered person* is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless we previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse us, the *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved.

# CLAIMS

## **Notice Of Claim**

*We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

## **Claim Forms**

*We*, within 10 working days after receipt of a notice of claim, will furnish to *you* or *your* covered *dependent* forms for filing proofs of loss. If the forms are not furnished within 10 days after the giving of notice, *you* shall be considered to have complied with the requirements of this policy as to proof of loss upon submitting, within 90 days of the *loss*, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

## **Proof Of Loss**

*You* or *your* covered *dependent* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

## **Cooperation Provision**

Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents deemed relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents deemed relevant;
3. Answer, under oath or otherwise, any questions deemed relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

## **Time For Payment Of Claims**

Benefits will be paid within 30 calendar days after receiving a clean claim. A clean claim is a claim that is free from defects or impropriety. If the clean claim is not paid within 30 days interest shall accrue at a rate of 15 percent annually beginning on the day following the day that the notice was due and will continue to accrue until the date that the claim is paid.

### **Payment Of Claims**

Except as set forth in this provision, all benefits are payable to *you*. Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to \$1,000 to any relative who, in *our* opinion, is entitled to it.

*We* may pay all or any part of the benefits provided by this *policy* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

### **Foreign Claims Incurred For Emergency Care**

Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

### **Assignment**

*We* will reimburse a *hospital* or health care provider if *your* health insurance benefits are assigned by *you* in writing.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that are determined to be due and payable under the *policy*.

### **Medicaid Reimbursement**

The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

*We* will pay the benefits of this *policy* to the state if:

1. A *covered person* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

*Our* payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

### **Insurance With Other Insurers**

If there is other valid coverage providing benefits on a provision of service or an expense incurred basis and of which *we* have not been given written notice prior to the occurrence or commencement of loss, *our* only liability under this *policy* shall be for a proportion of the loss as the amount which would otherwise have been payable plus the total of the like amounts under all such other valid coverages for the same loss of which *we* had notice bears to the total like amounts under all valid coverages. *We* shall return any

portion of the premiums paid that exceeds the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Other valid coverage shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations or any third party liability coverage.

### **Insurance With Medicare**

If a person is also a Medicare beneficiary, Medicare is always the primary plan. This means that benefits paid for *eligible expenses* by *your* plan will be reduced by the amount that Medicare pays.

### **Custodial Parent**

This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

### **Physical Examination**

*We* shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

### **Legal Actions**

No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

**Change of Beneficiary:** Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not

be requisite to surrender or assignment of this policy or to a change of beneficiary or beneficiaries, or to any other changes in this policy."



# GRIEVANCE AND COMPLAINT PROCEDURES

## INTERNAL PROCEDURES

### **Applicability/Eligibility**

The internal *grievance* procedures apply to any hospital or medical policy or certificate or conversion plans, but not to accident only or disability only insurance.

An Eligible grievant is:

1. A claimant;
2. Person authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a spouse, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

**Important:** *Adverse benefit determinations* that are not *grievances* will follow standard PPACA internal appeals processes.

### **Grievances**

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

*Grievances* will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

### Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *claimant* and the *claimant's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
  - a. That we have not resolved the *grievance*;
  - b. When *our* resolution of the *grievance* may be expected; and
  - c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and we will notify the *claimant* in writing with the appeal decision within the following timeframes:
  - a. Post-service claim: within 60 calendar days after receipt of the *claimant's* request for internal appeal;
  - b. Pre-service claim: within 30 calendar days after receipt of the *claimant's* request for internal appeal.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information;
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to a later section for information regarding internal *expedited grievances*.

#### Acknowledgement

Within five business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant's authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;
2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

Internal appeals must be decided within 18 working days (72 hours for urgent appeals).

#### Right to Appear

The claimant who filed the *grievance*, or the claimant's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting;

2. Reasonable accommodations must be provided to allow the claimant, or the claimant's authorized representative, to participate in the *grievance* panel.

#### Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual authorized to take corrective action on the *grievance*;
2. At least one individual holding the same professional license as the treating provider; and
3. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

#### Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

#### Written Grievance Response

*Grievance* response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
  - a. A clear explanation of the decision;
  - b. Reference to the specific plan provision on which the determination is based;
  - c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

- d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
- g. The date of service;
- h. The health care provider's name;
- i. The claim amount;
- j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
- k. The health plan's denial code with corresponding meaning;
- l. A description of any standard used, if any, in denying the claim;
- m. A description of the external review procedures, if applicable;
- n. The right to bring a civil action under state or federal law;
- o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
- p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
- q. A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable.

## Complaints

Basic elements of a *complaint* include:

1. The complainant is the claimant or an authorized representative of the claimant;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
  - a. Us, as the insurer; e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
  - b. Providers with whom *we* have a direct or indirect contract;
    - i. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial; and
    - ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and

6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant's authorized representative where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

### **Complaints received from the State Insurance Department**

The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

### **External Review**

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. *We* will pay for the costs of the external review performed by the independent reviewer.

### **Applicability/Eligibility**

The *Grievance* procedures apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal review process, the claimant has four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.

1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
  - a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; and
  - b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External review is available for *grievances* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions of coverage.*

### **External Review Process**

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
  - a. The individual was a covered person at the time the item or service was requested;
  - b. The service is a covered service under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
  - c. The claimant has exhausted the internal process; and
  - d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or , if the request is not complete, the additional information needed to make the request complete;
3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;
4. We will assign an IRO on a rotating basis from our list of contracted IROs;
5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.  
**Note:** For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider;
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
10. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice;
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

## GENERAL PROVISIONS

### Entire Contract

This *policy*, with the application and any rider-amendments is the entire contract between *you* and *us*. No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy*. No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

### Non-Waiver

If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

### Rescissions

No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *covered person*;
2. A copy of the application, and any amendments, has been furnished to the *covered person(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person*. A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

### Repayment For Fraud, Misrepresentation Or False Information

During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid relating to or associated with the fraud, misrepresentation, or false information.

### Conformity With State Laws

Any part of this *policy* in conflict with the laws of the state in which your policy was issued on this *policy's* *effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

### Conditions Prior To Legal Action

On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific *policy* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.