CELTIC INSURANCE COMPANY

Home Office: 77 West Wacker Drive Suite 1200
Chicago, Illinois 60601
1-800-714-4658

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.

This Policy is a legal contract between *you* and *us.* READ *YOUR* POLICY CAREFULLY.

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. This *policy* is a legal contract between the policyholder and Celtic Insurance Company.

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. Premium rates are guaranteed for a period of twelve (12) months. Please see the Premium section of the *policy* for additional information.

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.

Important Cancellation Information - Please Read The Provision Entitled, *Termination*, found on Page 43 of the policy.

As a cost containment feature, this policy contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. 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; network provider reductions or exclusions, 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;
3. Any *grievance* filed against a health care insurer; and
4. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be *medically necessary* for treatment of the claimant's medical condition and that expertise is not available in the provider network.

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.

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 determined by *us* 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;
4. A child placed with you for foster care; or
5. 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.

1. For *network providers* excluding Transplant Benefits: When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For non-*network providers*:
    a. When a *covered expense* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider.
    b. When a *covered expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider; and
    c. Except as provided under (1) and (2) above, when a *covered expense* excluding Transplant Benefits is received from a non-*network provider*, 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:
        i. The fee that has been negotiated with the provider;
        ii. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area;
        iii. 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*;
        iv. The fee charged by the provider for the services; or
        v. 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.

Essential Health Benefits include the following general categories and items and services within the categories:

(A) Ambulatory patient services;
(B) Emergency services;
(C) Hospitalization;
(D) Maternity and newborn care;
(E) Mental health and substance use disorder services, including behavioral health treatment;
(F) Prescription drugs;
(G) Rehabilitative and habilitative services and devices;
(H) Laboratory services;
(I) Preventive and wellness services and chronic disease management; and
(J) Pediatric services, including oral and vision care.

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.

Foster child means a minor (i) over whom a guardian has been appointed by the Clerk of Superior Court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

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, a 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 or ***Habilitative Services*** means health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language patholoty, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Certification means that some *covered expenses* require prior authorization. In order to receive coverage for certain expenses and benefits, *you* must obtain prior authorization.

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. 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, rhabomyosarcoma, 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, myofacial 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 out-of-pocket amount is the sum of the deductible amount, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance percentage* of *covered expenses*, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, Ambetter pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' *eligible service expenses*. A covered person's maximum out-of-pocket will not exceed the individual maximum out-of-pocket amount.

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, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor,

marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *covered person*, a *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.

Medically Necessary means those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease; and, except as allowed for clinical trials under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms;
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of the *insured person,* the *insured person's* family or the *provider*.

For *medically necessary* services, nothing in this definition precludes Celtic from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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 mean 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.

Network means a group of *physicians* and providers who have contracts that include an agreed upon price for health care expenses.

Network eligible expense means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network*

facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Non-network eligible expense means the *eligible expense* for services or supplies that are provided and billed by a non-*network provider.*

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 mean 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.

Sexual Dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

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*.

Coverage must be effective in the case of a birth, adoption, placement for adoption, or placement in foster care on one of the following:

1. On the date of birth, adoption, placement for adoption or placement in foster care;
2. At the option of the qualified individual or enrollee, on the first of the month following the birth, adoption or placement in foster care;
3. At the option of the qualified individual or enrollee, if the birth, adoption or placement in foster care occurs between the first of the month and the fifteenth day, then coverage is effective on the first of the following month or if the birth, adoption or placement in foster care occurs between the sixteenth of the month and the end of the month, the first of the second following month.

The qualified individual or enrollee must indicate the requested effective date on the enrollment form used to enroll a new dependent. If the qualified individual or enrollee chooses an effective date after the date of birth, adoption, placement for adoption or placement in foster care, no benefits will be allowed for medical expenses incurred prior to the effective date of coverage.

If the qualified individual or enrollee does not indicate a requested effective date then the effective date will default to the date of birth, adoption, placement for adoption or placement in foster care, as noted in option 1.

Adding A Newborn Child
An *eligible child* born to *you* or *your spouse* 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 a Foster Child
An *eligible child* legally placed in foster care with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted 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 diagnosed congenital defect(s) and *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*. 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 foster 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 physically residing with *you* or *your spouse,* appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the *foster child* with the intent that the *foster child* reside with *you* or *your spouse* on more than a temporary or short-term basis.

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 diagnosed congenital defect(s) and *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, 2016, the open enrollment period begins November 1, 2015 and extends through January 31, 2016. *Individuals* who enroll prior to December 15, 2015 will have an effective date of coverage on January 1, 2016.

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

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 rerate 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%.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage because actual provider charges may not be used to determine plan and *covered person's* payment obligations.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Network Availability
Your network is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

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.

North Carolina State Mandated Benefits
The following North Carolina state mandated benefits are covered in the policy: Diagnosis and treatment of lymphedema, emergency care, minimum inpatient stay following delivery of a baby, minimum benefit offerings for alcoholism/drug abuse treatment, access to nonformulary drugs, hearing aids, bone mass measurements, prescription drug contraceptives and devices, colorectal cancer screenings, newborn hearing screening, ovarian cancer surveillance tests, mammograms and cervical cancer screening, prostate cancer screenings, reconstructive breast surgery following a mastectomy, congenital defects and abnormalities, certain clinical trials, anesthesia and hospital charges for certain dental procedures, diabetes, minimum coverage for mental illness, certain off-label use for cancer treatment and TMJ joint dysfunction.

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 the Schedule of Benefits for more information regarding specific benefit, day or visit limits, if any. Medication management visits do not require prior authorization for *network providers*.

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); and

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. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *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;

4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners;*
5. *Covered expenses* for Cardiac rehabilitative therapy including the reconditioning the cardiovascular system through exercise, education, counseling and behavioral change; and
6. *Covered expenses* for Pulmonary rehabilitation including programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life.

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

Care ceases to be *rehabilitation* upon *our* determination 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 60 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 lifetime maximum of 1,000 hours; and
2. Intermittent private duty registered nurse visits, not to exceed 4 hours each will be applied towards the hourly lifetime maximum above.

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:

1. 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; or
2. For any other *hospice,* the lesser of the billed charge or $200 per day.

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. Services rendered by a certified fee-based practicing pastoral counselor;
11. For the cost and administration of an anesthetic;
12. For oxygen and its administration;
13. 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 six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing;
14. For *medically necessary* procedures involving any bone or joint of the face or head used to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, *sickness* or *bodily injury*.

a. Therapeutic procedures include splinting, intraoral prosthetic appliances used to reposition the bones or any other Coverage for *medically necessary* procedures involving any bone or joint of the jaw, face or nonsurgical treatment of temporomandibular joint dysfunction.
b. Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants or root canals.

15. For reconstructive breast surgery as a result of a partial or total mastectomy for breast cancer to reestablish symmetry between the two breasts. Coverage includes surgery and reconstruction of the diseased and non-diseased breast including reconstruction of the mastectomy site, creation of a new breast mound, creation of a new nipple/areolar complex, prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Coverage also includes augmentation mammoplasty, reduction mammoplasty and mastopexy of the non-diseased breast. Reconstruction of the breast and reconstruction of the nipple/areolar complex following a mastectomy are covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician. The decision to discharge the *covered person* following a mastectomy is to be made by the attending physician in consultation with the *covered person*. The length of postmastectomy hospital stay is based on the unique characteristics of each individual taking into consideration the health and medical history of the *covered person*.
16. Acupuncture treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits;
17. 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;
18. 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; and
19. For dental anesthesia charges which include anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.
20. For maternity care: 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;
21. For the diagnosis, evaluation, and treatment of lymphedema, including complex decongestive therapy, and self-management training and education, if the treatment is determined to be

medically necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice;

22. 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.
23. Congenital cleft lip and palate charges are *medically necessary* care and treatment including, but not limited to, oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate; prosthetic treatment such as obdurators, speech appliances and feeding appliances; orthodontic treatment and management; prosthodontic treatment and management; otolaryngology treatment and management; audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical therapy assessment and treatment. If an insured person with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this policy;
24. Bariatric surgery;
25. For the diagnosis, treatment and correction of any underlying causes of infertility for *covered persons*;
26. Thirty (30) chiropractic care visits per year;
27. Well baby visits and care;
28. Newborn hearing screenings;
29. Coverage for certain services related to the diagnosis, treatment and correction of any underlying causes of *sexual dysfunction* for all *covered persons*;
30. Obesity screenings for *covered persons*; and
31. For sterilization, including female tubal ligation and male vasectomies.

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 orthotic devices for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets;
4. For *medically necessary* genetic blood tests;
5. For one hearing aid per hearing-impaired ear every 36 months for *covered persons* under the age of 22 years. The coverage shall include all *medically necessary* hearing aids and services that are ordered by a *physician* or an audiologist licensed in this State. Only those persons authorized by

law to fit hearing aids, including individuals licensed under Chapter 93D of the General Statutes, are eligible to fit a hearing aid under this section. Coverage shall be as follows:

a. Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the *covered person*.
c. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

6. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
7. Nutritional counseling;
8. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
9. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
10. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;
11. 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;
12. For occupational therapy following a covered treatment for traumatic hand injuries;
13. 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;
14. Outpatient contraceptive services, including consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent *pregnancy* which have been approved by the FDA. This benefit does not include routine physical examinations;
15. For the treatment of lymphedema, including equipment, supplies, and gradient compression garments if the treatment is determined to be *medically necessary* and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.
    a. Gradient compression garments:
        i. Require a prescription;
        ii. Are custom-fit for the covered individual; and
        iii. Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.
16. For bone mass measurement charges for diagnosis and evaluation of osteoporosis or low bone mass. Bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that we will provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is *medically necessary*. "Qualified individual" means any one or more of the following: An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
    a. An individual with radiographic osteopenia anywhere in the skeleton.
    b. An individual who is receiving long-term glucocorticoid (steroid) therapy.
    c. An individual with primary hyperparathyroidism.
    d. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
    e. An individual who has a history of low-trauma fractures.
    f. An individual with other conditions or on medical therapies known to cause osteoporosis

or low bone mass.

Clinical Trials
For clinical trials, clinical trial coverage shall include phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, which involve: (1) the treatment of cancer or other life-threatening medical conditions, (2) are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, and (3) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered clinical trials must also meet the following requirements:

1. Involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
2. Approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The plan may also cover clinical trials sponsored by other entities.
3. Conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.
4. Only *medically necessary* costs of *health care services* associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and *medically necessary* monitoring, are required to be covered and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

Coverage is not required for the costs of services that are:

a) Not *health care services*,
b) Provided solely to satisfy data collection and analysis needs,
c) Related to investigational drugs and devices, and
d) Are not provided for the direct clinical management of the patient. Nothing in this section shall be construed to require a plan to pay or reimburse for non-FDA approved drugs provided or made available to a patient who received the drug during a covered clinical trial after the clinical trial has been discontinued. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the claim will be denied.

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 formulary drug listing, including prescription drugs which require prior approval, is available upon request.

Coverage is provided for prescription contraceptive drugs and devices. Coverage includes coverage for the insertion or removal of and any *medically necessary* examination associated with the use of the prescribed contraceptive drug or device.

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

You cannot refill a prescription until 75 percent of the supply has been used, except under certain circumstances during a state of emergency or disaster.

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, unless specified under the *policy*;
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 Exception Process

The Prescription Drug Exception Process is not a part of the Smart NC External Review.

<u>Standard exception request</u>

A *member*, a *member's* designee or a *member's* prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make our determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If *we* grant an external exception review of a standard exception request, *we* will provide coverage of the non-formulary drug for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

Pediatric Oral Expense Benefits

Covered expenses in this benefit subsection include the following for an *eligible child* until the end of the month in which the *eligible child* turns 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 once 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 for missing primary molars A, B, I, J, K, L, S and T;
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. Rebasing 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* until the end of the month in which the *eligible child* turns the age of 19 and 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 very 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.

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 from *network providers*. 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 when received from a *network provider*.

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.

Health Screening Charges:

1. Mammogram - Coverage for one mammogram per *calendar year* for a *covered person* or more often as recommended by a *physician*. Reimbursement shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission. If standards are not in effect, then the standards established by the U.S. Department of Health and Human Services shall apply until Medical Care Commission standards become effective. Facilities that do not meet the required standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram. *Eligible expenses* for a mammogram shall include a *physician's* interpretation of the results of the procedure, a radiologist and facility charges;
2. Cytology - Cervix - One cytologic screening per *calendar year* or more often if recommended by a *physician*. Coverage shall include the examination, the laboratory fee and the *physician's* interpretation of the laboratory results. When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, before performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered;
3. Prostate Cancer - Coverage for an annual prostate-specific antigen (PSA) test or equivalent test for the presence of prostate cancer shall be provided when recommended by a *physician*; and

4. Colorectal Cancer Screening- Coverage will be provided for a colorectal cancer examination and laboratory tests, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening, for any non-symptomatic *covered person* who is:
    a. At least 50 years of age, or
    b. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

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 *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:
1. Reasonable and necessary services related to the search for a donor;
2. Pre-transplant evaluation;
3. Pre-transplant harvesting;
4. 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;
5. High dose chemotherapy;
6. Peripheral stem cell collection;
7. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence* and
8. 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 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 a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
2. For animal to human transplants;
3. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation;
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
7. Related to transplants not included under this provision as a *listed transplant; and*

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *covered person*;
2. 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
3. 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. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization *you* must obtain authorization from *us* before the *covered person:*

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *network provider* to which the *covered person* was referred by a *non-network provider.*

The following services or supplies require prior authorization:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled nursing facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

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

How To Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained 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.*

Failure To Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *policy* Schedule of Benefits for specific details.

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.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

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 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 except as specifically provided under the *policy*;
4. For breast reduction or augmentation, excluding breast reconstruction following a mastectomy;
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 treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as specifically described in the Major Medical Expense Benefits section;
9. For expenses for television, telephone, or expenses for other persons;
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
11. For telephone consultations or for failure to keep a scheduled appointment;
12. 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;
13. For stand-by availability of a *medical practitioner* when no treatment is rendered;
14. 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;
15. 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 a child;
16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
17. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*;
18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;

19. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
20. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
21. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *policy*;
22. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
23. 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;
24. 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*;
25. 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;
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days;
27. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
28. 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;
29. 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;
30. 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*;
31. For or related to surrogate parenting;
32. For or related to treatment of hyperhidrosis (excessive sweating);
33. For fetal reduction surgery;
34. 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;
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or semi-professional sports; intercollegiate sports not including intramural sports;

parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; scuba/skin diving when diving 60 or more feet in depth; skydiving; bungee jumping; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;

36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
37. As a result of any *injury* sustained while at a *residential treatment facility;*
38. 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.
39. 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, unless specifically covered in the *policy*; 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; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; smoking cessation drugs, programs or services, except where required by federal or state law; transportation expenses, unless specifically described in this *policy*; and
40. 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, as determined by *us,* 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 any renewal premium be not paid within the time granted the *insured* for payment, a subsequent acceptance of premium by Celtic or by any agent duly authorized by *us* to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if Celtic or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the *policy* will be reinstated upon approval of such application by the *us*, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the *we* have previously notified the *insured* in writing of its disapproval of such application. The reinstated *policy* shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such *sickness* as may begin more than 10 days after such date. In all other respects the *insured* and Celtic 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. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of 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* 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. 12 months after the date renewal is declined.

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*.

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, upon receipt of a notice of claim, will furnish to *you* or *your* covered *dependent* such forms as are usually furnished by *us* for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice *you* or *your* covered *dependent* shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of 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 180 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 *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem 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
Within 30 calendar days after receipt of a claim, Celtic shall send by electronic or paper mail to the claimant:

- Payment of the claim;
- Notice of denial of the claim;

- Notice that the proof of loss is inadequate or incomplete;
- Notice that the claim is not submitted on the form required by Celtic or by applicable law;
- Notice that coordination of benefits information is needed in order to pay the claim;
- Notice that the claim is pending based on nonpayment of premiums.

Claim payments that are not made within the specified time frames shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by Celtic, interest on claim payments shall begin to accrue on the 31st day after Celtic received the additional information.

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:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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 *we* have determined to be due and payable.

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 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.

INTERNAL REVIEW

Overview

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or denies *your* request to authorize treatment or service (pre-service claim denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your appeal*, it is required to review its own decision. When the plan makes a claim decision, it is required to notify *you* (provide notice of an *adverse benefit determination*):

- The reasons for the plan's decision;
- *Your* right to file appeal the claim decision
- *Your* right to request an *external review*; and
- The availability of assistance from The North Carolina Department of Insurance.
- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
- When *you* request an *internal appeal*, the plan must give *you* its decision as soon as possible, but no later than:
- 72 hours after receiving *your* request when *you* are appealing the denial of a claim for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time.)
- 30 days for appeals of denials of non-urgent care *you* have not yet received.
- 60 days for appeals of denials of services *you* have already received (post-service denials).
- No extensions of the maximum time limits are permitted unless *you* consent.

Continuing Coverage*: The plan cannot terminate your benefits until all of the appeals have been exhausted.* ***However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims' payments it made during the time of the appeals.***

Cost and Minimums for Appeals: There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

Emergency medical services: If the plan denies a claim for an emergency medical service, *your* appeal will be handled as an *urgent appeal. The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").*

***Your* rights to file an appeal of denial of health benefits:** *You or your authorized representative, such as your health care provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:*

- Please include in *your* written appeal or be prepared to tell us the following:
- Name, address and telephone number of the insured person;
- The insured's health plan identification number;
- Name of health care provider, address and telephone number;
- Date the health care benefit was provided (if a post-claim denial appeal)
- Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and

- A copy of the notice of *adverse benefit determination.*

Rescission of coverage: If the plan rescinds *your* coverage, *you* may file an appeal according to the following procedures. The plan cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

Time Limits for filing an internal claim or appeal: *You* must file the internal appeal within 180 days of the receipt of the notice of claim denial (an adverse benefit determination). Failure to file within this time limit may result in the company's declining to consider the appeal.
In general, the health plan may unilaterally extend the time for providing a decision on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

- ***Your* Rights to a Full and fair review**. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.
- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give *you* a reasonable opportunity to respond prior to that date; and
- Before the plan can issue a *final internal adverse benefit determination* based on a new or additional rationale, *you* must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give *you* a reasonable opportunity to respond prior to that date.
- The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:
  1. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
  2. Information sufficient to identify the claim involved, including the date of service, the health care provider;
  3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have *sufficient information*; such a decision; however, will allow *you* to advance to the next stage of the claims process.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Non-urgent, pre-service claim denial
For a non-urgent *pre-service claim,* the plan will notify *you* of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact *you*, in writing, telling *you* the reasons why it needs more time and the date when it expects to have a decision for *you*, which should be no later than 15 days.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* claim. In which case, *you* may file an appeal.

The plan must make its decision within 48 hours after receipt of the information or at the end of the 45 days, whichever comes first.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your health care provider (physician) may contact us with the claim, orally or in writing.

If the claim for benefits is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* claim provided *you* have given us information sufficient to make a decision.

If *you* have not given us sufficient information, we will contact *you* as soon as possible but no more than 24 hours after we receive *your* claim to let *you* know the specific information we will need to make a decision. *You* must give us the specific information requested as soon as *you* can but no later than 48 hours after we have asked *you* for the information.

We will notify *you* of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours *you* had to provide the additional information.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of *your* medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

Simultaneous *urgent claim and expedited* internal review:
In the case of a claim involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the claimant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

The physician , if the physician certifies, in writing, that *you* has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize the life or health of *you* or jeopardize *your* ability to regain maximum function, *you* may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal.

Simultaneous urgent claim, expedited internal review and external review:
You, or *your* authorized representative, may request an expedited external review if both the following apply:

1. *You* have filed a request for an expedited internal review; and
2. After a final adverse benefit determination, if either of the following applies:
   a. *Your* treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review;
   b. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which *you* received emergency services, but has not yet been discharged from a facility.

Concurrent care decisions
Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify *you* that we have decided to reduce or terminate the treatment, we will give *you* notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If *you* have received approval for an ongoing treatment and wish *to extend the treatment* beyond what has already been approved, we will consider *your* appeal as a request for urgent care. If *you* request an extension of treatment at least 24 hours before the end of the treatment period, we must notify *you* soon as possible but no later than 24 hours after receipt of the claim.

An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 30 days after we have received *your* appeal. If we need more time, we will contact *you*, telling *you* about the reasons why we need more time and the date when we expect to have a decision for *you*,

which should be no later than 15 days, provided that the we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a "retrospective review." The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let *you* know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The claim then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get *your* consent if it wants more time after its first extension. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

GRIEVANCE AND COMPLAINT PROCEDURES

Availability of Grievance Process

There is a grievance process which allows an *insured person* the opportunity to resolve his grievances. The process is voluntary and is available for the review of any *policy*, decision or action that affects an *insured person*. The grievance process does not apply to grievances or appeals based solely on the basis that the policy does not provide or it limits benefits for the health care service in question, provided the exclusion of the specific service requested is clearly stated in the policy.

The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at PO Box 26387, Raleigh, NC 27611 or by telephone at 1-800-546-5664.

Grievance Procedures

- Filing a Grievance:
  Mail the grievance along with copies of any supporting documents to:
  CELTIC INSURANCE COMPANY
  ATTN: Appeal Officer
  77 West Wacker Drive, Suite 1200
  Chicago, Illinois 60601

- First Level Grievance Review:

  The first level grievance review is for standard, non-urgent grievances. A grievance may be submitted in writing by an insured person or an insured person's provider acting on the insured person's behalf. Within three (3) business days of receiving a first level grievance, Celtic will provide the insured person with the name, address, and telephone number of the person coordinating the review and instructions on submitting written material, including the address to which the material may be submitted. Attendance by the insured person is not permitted for the first level grievance review.

  The coordinator is an individual other than the person who initially handled the original matter that is the subject of the grievance. If the issue is a clinical one, at least one reviewer must be a medical doctor with appropriate expertise to evaluate the matter under consideration.

  Celtic will issue a written decision, in clear terms, to the insured person and the insured person's provider, if applicable, within thirty (30) days after receiving the grievance.

  The written decision must contain the following information:

  - The professional qualifications and licensure of the person or persons reviewing the grievance;
  - A statement of the reviewers' understanding of the grievance;

- The reviewers' decision in clear terms and the contractual or medical rationale in sufficient detail for the insured person to respond further to the reviewers' position;
- A reference to the evidence or documentation used as the basis for the decision;
- A statement advising the insured person of his/her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance;
- A notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. Services provided by the Managed Care Patient Assistance Program are available through the North Carolina Department of Insurance. To reach this Program, contact:

  Managed Care Patient Assistance Program
  North Carolina Department of Insurance
  1201 Mail Service Center
  Raleigh, NC 27699-1201
  (855) 408-1212 (Toll Free)
  (919) 807-6865 (Fax No.)
  E-mail: mcpa@ncdoj.gov

For a grievance concerning the quality of clinical care delivered by the insured person's provider, Celtic will acknowledge the grievance within ten (10) business days of receipt of the grievance. The acknowledgement must advise the insured person that:

(1) Celtic will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and
(2) State law does not allow for a second-level grievance review for grievances concerning quality of care.

- Second Level Grievance Review.

  Celtic makes available a second level grievance review process for insured persons who are dissatisfied with the first level grievance review decision or a utilization review appeal decision. An insured person or an insured person's provider, acting on the insured person's behalf, may submit a second level grievance.

  The request for a second-level grievance review must be made in writing. Within ten (10) business days of receiving the request, Celtic will provide the insured person with a statement of his rights under the second level grievance review and the name, address and telephone number of the person coordinating the review.

  If the second level grievance review involves a non-certification or clinical issue, all persons reviewing the grievance shall be providers who have appropriate expertise, including at least one clinical peer. A Celtic employee may be part of the second level grievance review panel if the review panel comprises three or more persons and Celtic used a clinical peer on an appeal of non-certification or a first level grievance.

  The insured person's rights include:

  - the right to request and receive from Celtic all information relevant to the case;
  - the right to attend the second level grievance review;

- the right to present his/her case to the review panel;
- submit supporting material prior to and at the review meeting;
- ask questions of any member of the review panel;
- to be assisted or represented by a person chosen by the insured person, including a provider, a family member or an attorney;

Celtic will convene a second-level grievance review panel for each request. The review panel will be comprised of individuals:

(1) who were not previously involved in any matter giving rise to the second-level grievance;
(2) who are not employees of Celtic or Celtic's utilization review agent; and
(3) who do not have a financial interest in the outcome of the review.

The review panel will schedule and hold a review meeting within 45 days of receiving the request for a second-level grievance review. Celtic will notify the insured person in writing at least fifteen (15) days prior to the review meeting date. A full review will be made regardless of the insured person's appearance at the meeting. Celtic will issue a written decision to the insured person and the insured person's provider, if applicable, within seven (7) business days after completing the review meeting.

The written decision will contain the following information:

- The professional qualifications and licensure of the members of the review panel;
- A statement of the review panel's understanding of the grievance and all pertinent facts;
- The review panel's recommendation to Celtic and the rationale behind that recommendation;
- A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
- The rationale behind Celtic's decision if it differs from the review panel's recommendation;
- For a review of a non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria that was used by the review panel to make the recommendation;
- A statement that the decision is Celtic's final determination in the matter. If the review concerned a non-certification and the decision is to uphold the initial non-certification, a statement advising the insured of the right to request an external review. The NC notice for external review provides the procedures to follow for requesting an external review and should be provided at this time;
- Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:
  The North Carolina Department of Insurance
  P.O. Box 26387, Raleigh, NC 27611
  1-800-546-5664; and
- A notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. Services provided by the Managed Care Patient Assistance Program are available through the North Carolina Department of Insurance. To reach this Program, contact:
  Managed Care Patient Assistance Program
  North Carolina Department of Insurance
  1201 Mail Service Center
  Raleigh, NC 27699-1201

(855) 408-1212 (Toll Free)
(919) 807-6865 (Fax No.)
E-mail: mcpa@ncdoj.gov

- Expedited Second Level Grievance Review.

  Celtic makes available an expedited review process for a non-certification or when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the insured person or jeopardize the insured person's ability to regain maximum function. Celtic requires documentation of the medical justification for the expedited review.

  Celtic, in consultation with a medical doctor licensed to practice medicine in North Carolina, who was not involved in the non-certification, will provide the expedited review. The review meeting may take place via a telephone conference call or through the exchange of written information. Celtic will communicate its decision in writing to the insured person and his/her provider as soon as possible, but not later than four (4) days after receiving the information justifying the expedited review.

  The written decision will contain the following information:
  - The professional qualifications and licensure of the person or persons reviewing the grievance or appeal of non-certification;
  - A statement of the reviewers' understanding of the grievance or appeal of non-certification;
  - The reviewers' decision in clear terms and the contractual or medical rationale in sufficient detail for the insured person to respond further to Celtic's position;
  - A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination.
  - The rationale behind Celtic's decision if it differs from the review panel's recommendation;
  - A statement that the decision is Celtic's final determination in the matter;
  - A statement advising the insured of their right to request an external review. The NC notice for external review provides the procedures to follow for requesting an external review and should be provided at this time;
  - Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:
    The North Carolina Department of Insurance
    PO Box 26387, Raleigh, NC 27611
    1-800-546-5664
  - A notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

EXTERNAL REVIEW

North Carolina law provides for review of non-certification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to *you*, arranging for an IRO to review *your* case once the NCDOI establishes that your request is complete and eligible for review. *You* or someone you have authorized to represent you may request an external review. Celtic will notify *you* in writing of your right to request an external review each time you:

- Receive a non-certification decision; or
- Receive an appeal decision upholding a non-certification decision; or
- Receive a second-level grievance review decision upholding the original non-certification.

In order for your request to be eligible for external review, the NCDOI must determine the following:

- That *your* request is about a medical necessity determination that resulted in a non-certification decision;
- That *you* had coverage with Celtic in effect when the non-certification decision was issued;
- That the service for which the non-certification was issued appears to be a covered service under your policy; and
- That *you* have exhausted Celtic's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

- **Standard External Review**

For a standard external review, *you* will be considered to have exhausted the internal review process if you have:

- Completed Celtic's appeal and second level grievance review and received a written second level determination from Celtic; or
- Filed a second level grievance and except to the extent that *you* have requested or agreed to a delay, have not received Celtic's written decision within 60 days of the date *you* submitted the request, or
- Received notification that Celtic has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

If *your* request for a standard external review is related to a retrospective non-certification (a non-certification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed Celtic's internal review process and received a written final determination from Celtic.

If *you* wish to request a standard external review, *you* (or *your* representative) must make this request to NCDOI within 120 days of receiving Celtic's written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of *your* request for a standard external review, the NCDOI will notify

you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of Celtic's written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- The name and contact information for the Independent Review Organization (IRO) assigned to your case;
- A copy of the information about your case that Celtic has provided to the NCDOI;
- Notification that Celtic will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- Notification that you may submit additional written information and supporting documentation relevant to the initial non-certification to the assigned IRO within seven (7) days of the date of the acceptance notice.

If you choose to provide any additional information to the IRO, you must also provide that same information to Celtic at the same time using the same means of communication (e.g., you must fax the information to Celtic if you faxed it to the IRO). When faxing information to Celtic, send it to 1-312-441-0822. If you choose to mail your information, send it to:

Celtic Insurance Company
Attn: Claims
77 W. Wacker Drive, Suite 1200
Chicago, IL 60601

Please note that you may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and Celtic. The NCDOI will forward this information to the IRO and Celtic within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the non-certification, Celtic will, reverse the non-certification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the non-certification decision. If you are no longer covered by Celtic at the time Celtic receives notice of the IRO's decision to reverse the non-certification, Celtic will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

- **Expedited External Review**

An expedited external review of a non-certification decision may be available if *you* have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize *your* life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, *you* may make a written or verbal request to the NCDOI for an expedited review after *you*:

- Receive a non-certification decision from Celtic AND file a request with Celtic for an expedited appeal; or
- Receive an appeal decision upholding a non-certification decision AND file a request for an expedited second level grievance review; or
- Receive a second-level grievance review decision upholding the original non-certification.

You may also make a request for an expedited external review if you receive an adverse second-level grievance review decision concerning a non-certification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 calendar days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if Celtic's internal review process was already completed, or (2) require the completion of Celtic's internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective non-certifications.

The IRO will communicate its decision to *you* within 3 calendar days of the date the NCDOI received *your* request for an expedited external review. If the IRO's decision is to reverse the non-certification, Celtic will, within one day of receiving notice of the IRO's decision, reverse the non-certification decision for the requested service or supply that is the subject of the non-certification decision. If *you* are no longer covered by Celtic at the time Celtic receives notice of the IRO's decision to reverse the non-certification, Celtic will only provide coverage for those services or supplies *you* actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

The IRO's external review decision is binding on Celtic and *you*, except to the extent *you* may have other remedies available under applicable federal or state law. *You* may not file a subsequent request for an external review involving the same non-certification decision for which *you* have already received an external review decision.

For further information about external review or to request an external review, contact the NCDOI at:

By Mail: NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
(Fax) 919-807-6865

In Person: For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart/Smart Contacts.aspx
Toll-free telephone number 855-408-1212
www.ncdoi.com/Smart for External Review and Request Form

The Healthcare Review Program is available to provide Consumer Counseling on utilization review and internal appeals and grievance issues.

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.

We will provide 30 days’ notice to the *covered person* prior to recession.

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 during the time the *covered person* was insured under the *policy*.

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*.