



COVENTRY HEALTH CARE OF IOWA, INC.
HEALTH MAINTENANCE ORGANIZATION
OPEN ACCESS
EVIDENCE OF COVERAGE

Welcome to Coventry Health Care of Iowa, Inc.!

We are extremely pleased to have You enrolling in Our Health Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other Providers to offer a broad range of services for Your medical needs.

As a Coventry Health Care of Iowa, Inc. Member, it is important that You understand the way Your health plan operates. This Evidence of Coverage contains the information You need to know about Your coverage with Us.

Please take a few minutes to read these materials and to make Your covered family members aware of the provisions of Your coverage. Our Customer Service Department is available to answer any questions You may have about Your coverage. You can reach them at (800) 257-4692 Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Standard Time, or by logging on to Our website at www.chciowa.com.

We look forward to serving You and Your family.

Sincerely,

A handwritten signature in black ink that reads "Charles R. Stark". The signature is written in a cursive, flowing style.

Charles R. Stark

Chief Executive Officer

Coventry Health Care of Iowa, Inc.

Evidence of Coverage

The Agreement between Coventry Health Care of Iowa, Inc. (hereafter called “Health Plan”, “We”, “Us”, or “Our”) and You the Member is made up of:

This Evidence of Coverage and any Amendments or Riders hereto;
The Schedule of Benefits;
Any Enrollment Form or Statement of Health You completed; and
The Group Master Contract.

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an Officer of the Health Plan, and the resulting waiver, change, or amendment is attached to this Agreement. This Agreement begins on the date defined in the Group Master Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the Health Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Agreement.

THIS EVIDENCE OF COVERAGE (EOC) SHOULD BE READ AND RE-READ IN ITS ENTIRETY.

Many of the provisions of this EOC are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Evidence of Coverage have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, this Agreement may be amended. When that occurs, We will provide an Amendment or new Evidence of Coverage to You. You should keep this document in a safe place for Your future reference.

Coventry Health Care of Iowa, Inc.
4320 114th Street
Urbandale, IA 50322
800-257-4692

TABLE OF CONTENTS

SECTION 1 : DEFINITIONS8

SECTION 2 : USING YOUR BENEFITS.....16

2.1 Membership Identification (ID) Card16

2.2 Your Primary Care Physician (“PCP”).....16

2.3 Selecting Your Primary Care Physician (“PCP”).....16

2.4 Health Services Rendered by Participating Providers17

2.5 Out-of-Network Exception17

2.6 Member Responsibility.....17

2.7 How to Contact the Health Plan17

SECTION 3 : UTILIZATION MANAGEMENT.....17

3.1 Utilization Management Program.....17

3.2 Utilization Management Reviews.....18

3.3 Prior Authorization Requirements18

3.4 Case Management.....19

SECTION 4 :SUBSCRIBER ELIGIBILITY19

SECTION 5 : DEPENDENT ELIGIBILITY19

5.1 General Dependent Eligibility Requirements19

5.2 Eligible Dependents19

5.3 Individuals not Eligible for Dependent Coverage20

SECTION 6 : ENROLLMENT20

6.1 Group Enrollment Period.....20

6.2 New or Transfer Employees20

6.3 Valid Waiver.....20

6.4 Special Enrollment Period21

6.5 Notification of Change in Status.....22

SECTION 7 : EFFECTIVE DATES22

7.1 Effective Dates.....22

SECTION 8 : COVERED SERVICES23

8.1 Table of Covered Services24

8.2	Emergency Benefits.....	46
8.3	Mental Disorders, Substance-Related Disorders, and Biologically Based Mental Illness Services	46
8.4	Transplant Services.....	47
	SECTION 9 : EXCLUSIONS AND LIMITATIONS.....	47
9.1	GENERALLY EXCLUDED SERVICE /ITEMS	47
9.2	SPECIFICALLY EXCLUDED SERVICES	48
	SECTION 10 : CLAIMS AND REIMBURSEMENT	52
10.1	Notice of Claims	52
10.2	Proof of Loss.....	52
10.3	Claims Payment	52
10.4	Physical Examination	52
	SECTION 11 : COORDINATION WITH OTHER COVERAGE (COORDINATION OF BENEFITS-COB)	52
11.1	Coordination With Other Plans.....	52
11.2	Definitions of Terms Used in this Section.....	53
11.3	Order of Benefit Determination Rules.....	54
11.4	Effect On The Benefits of this Health Plan	56
11.5	Coordination of Benefits with Medicare	57
11.6	Right of Recovery.....	57
11.7	Right to Receive and Release Needed Information	58
11.8	Facility of Payment.....	58
	SECTION 12 : TERMINATION OF COVERAGE	58
12.1	Termination of Coverage by Group.....	58
12.2	Termination of Coverage by Us.....	58
12.3	Effect of Termination.....	59
12.4	Certificates of Creditable Coverage.....	59
12.5	Notification of Termination.....	59
	SECTION 13 : CONTINUATION, EXTENSION AND CONVERSION, OF COVERAGE.....	59
13.1	Introduction.....	59
13.2	Continuation Coverage Under COBRA	

(Consolidated Omnibus Budget Reconciliation Act).....60

13.3 Eligibility for Continuation Coverage Under COBRA.....60

13.4 Election Period and Premium Requirements for Continuation Coverage Under COBRA ..60

13.5 Length of Coverage Under COBRA.....61

13.6 Termination of Continuation Coverage Under COBRA61

13.7 Certificates of Creditable Coverage.....61

13.8 Iowa Continuation Coverage61

13.9 Termination of Iowa Continuation Coverage62

13.10 Extension of Coverage if a Member is an inpatient in a Hospital or Nursing Facility.....62

13.11 Extension of Coverage Upon Total Disability.....62

SECTION 14 : COMPLAINTS AND GRIEVANCES62

14.1 Procedure for Filing an Inquiry, Complaint, or Appeal.....63

14.2 Pre-Service Appeal Process64

14.3 Post-Service Appeal Process64

14.4 Urgent Care/ Expedited Appeals64

14.5 External Review.....65

14.6 Department of Insurance Review65

SECTION 15 : CONFIDENTIALITY OF YOUR MEDICAL RECORDS65

SECTION 16 : RIGHT OF RECOVERY (THIRD PARTY LIABILITY SUBROGATION).....66

SECTION 17 : GENERAL PROVISIONS66

SECTION 18 : SERVICE AREA DESCRIPTION68

SECTION 1: DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement. Any singular word shall have the same meaning as any plural of the same word.

1.1 “Actively-at-Work”

The employment status required to be eligible for Coverage as defined by the Group Master Contract.

1.2 “Adverse Benefit Determination”

1.2.1 A utilization review determination by Us that, based upon the information provided, an admission, availability of care, continued stay, or other health care service has does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced, or terminated and payment is not provided or made in whole or in part; or

1.2.2 A denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by Us of Your eligibility for Coverage by the Health Plan.

1.3 “Agreement”

This Evidence of Coverage and Amendments, the Enrollment Form, the Schedule of Benefits, applicable Riders, and the Group Master Contract together form this Agreement.

1.4 “Allowable Amount”

This is the maximum amount the Health Plan has determined is eligible for payment for each Covered Service, before any Deductible, Copayments, Coinsurance or penalties are applied.

For In-Network services this is the amount Participating Providers have contractually agreed to accept as payment for Covered Services they provide to Health Plan Members. It is from this amount that

any Deductible, Copayments and Coinsurance are deducted prior to issuing payment.

Out-of-Network Services are not Covered except for Emergency Services.

1.5. “Amendment”

Any description of changes, additions or deletions to Covered Services that is attached to the Evidence of Coverage. Amendments are effective only when issued by the Plan and are subject to all conditions, limitations and exclusions in the Evidence of Coverage that are not specifically superseded by the Amendment. In the event of a conflict between the Evidence of Coverage and the Amendment, the Amendment will apply.

1.6 “Appeal”

An Appeal is a request by the Member or Member’s Authorized Representative for consideration of an Adverse Benefit Determination.

1.7 “Authorized Representative”

An Authorized Representative is an individual authorized by the Member to act on the Member’s behalf in obtaining claim payment or during the Appeal process. A Provider may act on behalf of a Member with the Member’s express consent, or without the Member’s express consent in emergent situations.

1.8 “Benefit Year”

The period during which the total amount of yearly benefits under Your Coverage is calculated. The applicable time period is indicated on Your Schedule of Benefits as either a contract year or calendar year. A contract year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary. A calendar year is the period of twelve (12) consecutive months commencing on January 1st and continuing through December 31st of that year.

1.9 “Biologically Based Mental Illness”

The following psychiatric illnesses as defined in the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric

Association (“APA”):

- (a) schizophrenia;
- (b) bipolar disorders;
- (c) major depressive disorders;
- (d) schizo-affective disorders;
- (e) obsessive-compulsive disorders;
- (f) pervasive developmental disorder; and
- (g) autistic disorders.

1.10 “COBRA”

The Consolidated Omnibus Budget Reconciliation Act, as amended.

1.11 “Coinsurance”

Coinsurance means the amount, calculated using a percentage, that You are responsible for paying when You receive certain Covered Services. The percentage amount is calculated as a percentage of the Allowable Amount after any Deductible, Copayment, or penalties have been deducted.

1.12 “Complaint”

Any expression of dissatisfaction expressed by a Member or Member’s Authorized Representative regarding Coverage that does not rise to the level of an Appeal.

1.13 “Convenient Care Clinic”

A medical clinic located in a retail location such as a grocery or drug store, where a Provider offers treatment of minor medical conditions, immunizations, and physicals without an appointment.

1.14 “Copayment”

A specified dollar amount You must pay as a condition of the receipt of certain services as provided in the Schedule of Benefits. The Copayment may be collected directly by the Provider at the time of service.

1.15 “Cosmetic”

A procedure, service, surgery or supply: (i) from which no significant improvements in physiologic function could be reasonably expected; (ii) that does not meaningfully promote the proper function of the body

or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body. Surgery performed solely to address psychological or emotional factors is considered cosmetic.

1.16 “Coventry Approved Transplant Facility”

A facility that directly or indirectly has a contract with the Health Plan and is designated as a Center of Excellence for particular transplants.

1.17 “Cover” or “Covered” or “Coverage”

The entitlement of a Member to Covered Services or a particular Covered Service as provided under this Agreement, and subject to all terms, conditions, limitations and exclusions of the Agreement, including the following conditions:

- 1.17.1** health services, treatment, and devices must be provided after the Member’s Effective Date to be Covered; and
- 1.17.2** health services, treatment, and devices must be provided prior to the date that any of the termination conditions listed under this Agreement occur, including but not limited to termination of the Group Master Contract or termination of the Member’s Coverage;
- 1.17.3** health services, treatment, and devices must be provided only when the recipient meets all eligibility requirements specified in the Agreement, regardless of whether the Member or Group has submitted a Change Form or terminated Coverage; and
- 1.17.4** health services, treatment, and devices must be determined Medically Necessary by Us; and
- 1.17.5** health services, treatment, and devices listed as “Covered Services” in the Agreement.

1.18 “Covered Individual”

Any Member who meets the eligibility requirements described in the Agreement and is enrolled for Coverage in accordance with the terms and conditions of this Agreement. See “Member.”

1.19 “Covered Services/Covered Service”

The services or supplies provided to You for which the Health Plan will make payment, as described in this Agreement.

1.20 “Deductible”

The amount You must pay for Covered Services each Benefit Year before benefits are payable by Us. This amount, if applicable, is listed in Your Schedule of Benefits.

1.21 “Dependent”

Any member of a Subscriber’s family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid.

1.22 “Durable Medical Equipment” “DME”

Medical equipment Covered under the Agreement, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home, including Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment.

1.23 “Effective Date/ Member Effective Date”

The date entered on Our records as the date when Coverage for a Member under this Agreement begins. Coverage will take effect at 12:01 a.m. on the date required under the terms of this Agreement.

1.24 “Emergency Medical Condition/ Emergency”

"Emergency Medical Condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 1.24.1 serious jeopardy to the health of the individual (or unborn child) or in the case

of a behavioral condition, placing the health of the individual or others in serious jeopardy;

- 1.24.2 serious impairment to any bodily functions;
- 1.24.3 serious impairment to any bodily organ or part;
- 1.24.4 serious disfigurement.

1.25 “Emergency Services”

Covered inpatient and outpatient services that are:

- 1.25.1 rendered by a Provider qualified to provide treatment of an Emergency Medical Condition; and
- 1.25.2 necessary to evaluate or stabilize an Emergency Medical Condition.

1.26 “Employee”

A person who receives compensation from the Group for work performed for the Group. An Employee will not include a person who is unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

1.27 “Enrollment Form, Enrollment/Change Form, and/or Statement of Health”

Your application for enrollment in the Health Plan.

1.28 “Experimental or Investigational”

A service, supply, equipment, drug or procedure is deemed experimental or investigational if one or more of the following conditions are met:

- 1.28.1 Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug for which Prior Authorization is requested that is proposed for off-label use, except as otherwise required by state law;
- 1.28.2 Any service, supply, equipment, drug or procedure that is subject to the review and/or approval of Our corporate medical management team ;

- 1.28.3 Any service, supply, equipment, drug or procedure that is the subject of a clinical trial that meets criteria for Phase I or II, as set forth by FDA regulations, or Phase III approved for the treatment of Cancer by the National Institute of Health;
- 1.28.4 Any service, supply, equipment, drug or procedure that is considered not to have demonstrated value based on clinical evidence reported by peer-reviewed medical literature and by generally recognized academic experts.

1.29 “Family Deductible”

The Family Deductible is the amount that must be paid for Covered Services each Benefit Year by Members of a family before benefits will be payable by the Health Plan. The Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. The expenses of each Member counted towards the Family Deductible is limited to their Individual Deductible amount. If there are only two Members in a family and each satisfy the Individual Deductible, the Family Deductible is Considered satisfied. The Family Deductible and Individual Deductible are listed on the Schedule of Benefits.

1.30 “Full-Time Student”

An individual who is enrolled and attending, full-time, a recognized course of study or training at:

- 1.30.1 an accredited high school or vocational school;
- 1.30.2 an accredited college or university; or
- 1.30.3 a licensed technical school, beautician school, automotive school, or similar training school.

Full-time status is determined in accordance with the standards set forth by the educational institution and includes periods of scheduled vacation or breaks established by the educational institution as long as the individual continues at full-time status following the break. A student is no longer considered a Full-Time Student at the end of the month of graduation or when full-time enrollment ceases.

1.31 “Grievance”

A written complaint, or an oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a Member regarding any aspect of the Health Plan, relative to the Member, such as:

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

1.32 “Group”

An organization or firm contracting with the Health Plan to arrange health care services for their Employees, and through which eligible Subscribers and Dependents enroll and become entitled to the benefits described herein.

1.33 “Group Master Contract”

The agreement between the Group and Us that states the agreed upon contractual rights and obligations of the Health Plan, the Group, and Members, and that describes the costs, procedures, conditions, limitations, exclusions, and other obligations afforded to Members.

1.34 “Group Effective Date”

The date that is specified in the Group Master Contract as the effective date of this Agreement.

1.35 “Group Enrollment Period”

Shall mean a period of time occurring at least once annually during which time any eligible Employee and Dependents may enroll with the Health Plan for Coverage under this Evidence of Coverage.

1.36 “Health Plan”

Coventry Health Care of Iowa, Inc. (the Health Plan).

1.37 “High Technology Diagnostics”

Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics which include, but are not limited to, procedures as defined by Us, such as ultrafast computed tomography (UFCT), magnetic resonance imaging (MRIs), magnetic resonance angiogram (MRAs), computerized tomography scan (CT Scans), positron emission tomography scan (PET Scans), single photon emission computed tomography scan (SPECT Scans), some types of ultrasounds and other nuclear radiology.

1.38 “Hospital”

An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

1.39 “Individual Deductible”

The amount an individual Member must pay for Covered Services each Benefit Year before benefits are payable by the Health Plan.

1.40 “Infertility”

Infertility means the inability of an individual to conceive a pregnancy or produce conception after one year of unprotected intercourse between a man and a woman or the inability of a woman to carry a pregnancy to live birth.

1.41 “In-Network”

Any Provider who is Participating, because they have entered into a direct or indirect written agreement with Us to provide health services to Members.

1.42 “Inquiry”

Any question from a Member or Member’s Authorized Representative regarding Coverage that does not rise to the level of an Appeal (e.g., benefits information, claim status, or eligibility).

1.43 “Jaw Joint Disorder”

Includes temporomandibular joint disorder and craniomandibular disorder. It does not include a fracture or dislocation which results from an Injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).

1.44 “Limiting Age”

The maximum age a non-Spouse Dependent attains and still maintains eligibility under the terms of this Agreement. The Limiting Age is as provided in the Evidence of Coverage, unless an older age is agreed upon in the Group Master Contract.

1.45 “Maximum Benefit”

The Maximum Benefit is the sum of the amounts paid for a Member’s claims incurred during a Benefit Year. A Maximum Benefit may apply to a specific benefit and/or all benefits received during a Benefit Year. Please refer to the Schedule of Benefits for all Maximum Benefit limits that apply to Your Agreement.

1.46 “Maximum Lifetime Benefit”

The Maximum Lifetime Benefit is the maximum benefit for a Member during the entire time the member is covered by the Group without regard to health insurance carrier. All amounts paid for a Member’s claims will be counted towards the Maximum Lifetime Benefit until the amount listed in the current Schedule of Benefits has been reached. Once the Maximum Lifetime Benefit amount listed in

the current Schedule of Benefits has been reached, no further benefits will be paid by the Health Plan.

The Maximum Lifetime Benefit will include any Allowable Amounts even if the Member has a break in Coverage or terminates Coverage through the Group and later re-enrolls under the same Group.

1.47 “Medical Director”

The Physician specified by Us as the Medical Director or other Health Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

1.48 “Medically Necessary/Medical Necessity”

Medically Necessary means those services, supplies, equipment and facilities charges that are not expressly excluded under this Agreement and determined by Us to be:

- 1.48.1** Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- 1.48.2** Necessary to improve physiological function and required for a reason other than improving appearance;
- 1.48.3** Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- 1.48.4** Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
- 1.48.5** Consistent with the diagnosis of the condition at issue;
- 1.48.6** Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- 1.48.7** Not Experimental or Investigational as determined by Us under Our Experimental

Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from Our Member Services Department.)

1.49 “Member”

Any Subscriber, Dependent or Qualified Beneficiary (as the term is defined under COBRA) who is enrolled for Coverage in accordance with the terms and conditions of this Agreement.

1.50 “Mental Disorder”

A clinically significant syndrome or pattern that falls under a diagnostic category listed in the Mental Disorders Section of the Diagnostic and Statistical Manual.

Mental Disorder does not include:

- 1.50.1** mental retardation and disorders relating to learning, motor skills, communication, feeding and eating in infancy and early childhood;
- 1.50.2** conditions not attributable to a Mental Disorder described in the Diagnostic Manual as "V" codes, such as: relational problems, anti-social behavior, academic problems and phase-of-life problems; and
- 1.50.3** delirium, dementia, amnesia, and cognitive disorders without psychiatric complications.

1.51 “Non-Participating Provider/Non-Participating”

A Provider who has no direct or indirect written agreement with Us to provide health services to Members.

1.52 “Officer”

The person holding the office of President and/or CEO of the Health Plan or his or her designee.

1.53 “Out-of-Network”

Any Provider who is Non-Participating, because they have not entered into a direct or indirect written

agreement with Us to provide health services to Members.

1.54 “Out-of-Pocket Maximum”

The individual Out-of-Pocket Maximum is a limit on the amount a [Member][or][Subscriber] must pay out of his or her pocket for Covered Services in a Benefit Year. The family Out-of-Pocket Maximum is the limit on the total amount Members of the same family Covered under this Agreement must pay for specified Covered Services in a Benefit Year. Penalties and expenses for non-Covered Services do not apply to the Out-of-Pocket Maximum. Individual and Family Out-of-Pocket Maximum amounts and descriptions are listed in the Schedule of Benefits.

1.55 “Participating Provider/Participating”

A Provider who has entered into a direct or indirect written agreement with Us to provide health services to Members. “Participating” refers only to those Providers included in the network of Providers described in the provider directory. The participation status of Providers may change from time to time.

1.56 “Premium”

The monthly fee required to be paid on behalf of each Member in accordance with the terms of the Group Master Contract/Agreement.

1.57 “Preventive” or “Preventive Services”

These services are focused on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for specific problems, and interventions to avert a health problem in non-symptomatic individuals. Please refer to the Covered Services Section for a list of Preventive Services Covered under this Agreement.

1.58 “Prior Authorization /Authorization /Authorized”

Verification of Medical Necessity by the Health Plan, for certain services, supplies, equipment, drugs or procedures to be received by a Member. Authorization does not guarantee payment if You are not eligible for

Covered Services at the time the service is provided or it is not a Covered Service.

1.59 “Pre-Service Appeal”

Pre-Service Appeals are those Appeals for which a requested service requires Prior Authorization, an Adverse Benefit Determination has been rendered, and the requested service has not been provided.

1.60 “Post-Service Appeal”

Post-Service Appeals are those Appeals for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

1.61 “Primary Care Physician (“PCP”)

This is the Participating Physician who practices in the fields of Internal or General Medicine, Family Practice, Obstetrics and Gynecology, or Pediatrics who is designated as a PCP by Us.

1.62 “Provider”

A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

1.63 “Physician”

Any Doctor of Medicine, “M.D.”, or Doctor of Osteopathy, “D.O.”, who is duly licensed and qualified under the law of the jurisdiction in which treatment is received. Physician does not include an immediate relative of a Member unless otherwise required by state law.

1.64 “Qualified Medical Child Support Order”

A medical child support order, issued by a court of competent jurisdiction or through an administrative process established under state law, which creates or recognizes the existence of a child or children’s right to receive Coverage for which a Member is entitled in accordance with applicable state and federal laws.

The order must be submitted to the Health Plan and determined by Us to satisfy the requirements of section 609(a) of ERISA (29 USC § 1169 (a)).

1.65 “Rider”

Any description attached to the Evidence of Coverage that modifies its benefits. Coverage provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when issued by the Health Plan and are subject to all conditions, limitations and exclusions in the Evidence of Coverage that are not specifically superseded by the Rider. In the event of a conflict between the Evidence of Coverage and the Rider, the Rider will apply.

1.66 “Self-Injectables”

Injectable prescription drugs as specified in the Health Plan’s formulary list, that are commonly and customarily administered by the Member according to clinical guidelines used by the Health Plan.

1.67 “Service Area”

The geographic area served by the Health Plan as approved by the State of Iowa and shown on the Service Area description in this Evidence of Coverage. The Health Plan’s Service Area is subject to change.

1.68 “Specialty Care Physician/Specialist”

A Physician who provides medical services to Members within the range of a medical specialty and who is not acting as a Primary Care Physician.

1.69 “Spouse”

A person to whom the Subscriber is validly married under the law of the state where the Subscriber resides. A common law spouse qualifies as a Spouse under this Agreement only if his/her spousal status is affirmed by a court of competent jurisdiction.

1.70 “Subscriber”

The eligible Employee who has elected the Health Plan’s Coverage through submission of an Enrollment/Change Form and for whom, or on whose

behalf, Premiums have been received by the Health Plan.

1.71 “Substance-Related Disorder”

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

1.72 “Temporomandibular Joint Disorder (“TMJ”)

See definition of “Jaw Joint Disorder.”

1.73 “Therapeutic Injections and IV Infusions”

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Member.

1.74 “Total Disability, Totally Disabled or Disabled”

Complete inability of the Member to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Member to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete inability of the Member to engage in most of the normal activities of a person of like age and gender. The disability, for Subscriber or Dependent, must require regular care and attendance by a Physician who is someone other than an immediate family member.

1.75 “Uniformed Services”

The United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

1.76 “Urgent Care”

Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt

medical attention.

1.77 “Urgent Care Appeal”

An Urgent Care Appeal is an Appeal that must be reviewed under an expedited appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize (a) the life or health of the Member; or (b) the Member’s ability to regain maximum function. In determining whether an Appeal involves Urgent Care, We will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

An Urgent Care Appeal is also an Appeal involving: (a) care that the treating Physician deems urgent in nature; or (b) the treating Physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

1.78 “Urgent Care Facility”

A facility specifically set up for Providers to offer Urgent Care on a walk-in basis, as an alternative to a Hospital or Emergency room or a Primary Care Physician or Specialist office visit.

1.79 “We/Us or Our”

The Health Plan.

1.80 “You/Your”

A Member covered under this Agreement.

SECTION 2: USING YOUR BENEFITS

We will pay benefits only for the Covered Services stated in this Evidence of Coverage that are incurred by You while insured under the Agreement. These charges must be for Medically Necessary treatment.

We are able to offer health care services to You through a network of Participating Providers. Participating Providers are the Providers who have contracted with Us to provide Our Members with health care services and/or supplies at a contracted rate. We reserve the right to make changes in Our network

of Participating Providers as is appropriate or necessary. If a Provider does not have a contractual arrangement with Us, they are considered Non-Participating.

You may check with a customer service representative or the provider directory to see if a Provider is Participating. Provider participation can also be verified by accessing Our website, www.chciowa.com.

2.1 Membership Identification (ID) Card

Every Health Plan Member receives a membership ID card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive health care services. Your ID card tells Providers who to bill for Your services. If You do not present Your ID card prior to receiving health care services, You may be billed. If Your Health Plan ID card is missing, lost, or stolen, contact the Health Plan Customer Service Department at (800) 257-4692 to obtain a replacement or visit Our website at www.chciowa.com.

Possession and use of an ID card is not an entitlement to payment or reimbursement for all services received. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

2.2 Your Primary Care Physician (“PCP”)

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. You and Your PCP will work together to maintain Your health, and Your PCP will provide or coordinate most of Your health care needs. This may include preventive health services, obtaining Authorization of certain services, consultation with Specialists and other Providers, and Emergency Services. Some health services must be Prior Authorized by the Health Plan prior to the rendering of such services.

2.3 Selecting Your Primary Care Physician (“PCP”)

Members may choose their PCP from the provider directory, a list of Participating family and general practitioners, internists, obstetricians/gynecologists and pediatricians. When selecting a PCP, You may wish to contact individual Provider offices for additional information such as specifics of a Physician’s training and experience or office hours and policies. One PCP

may be selected for the entire family, or each Dependent may select a different PCP.

2.4 Health Services Rendered by Participating Providers

Health services described in this Agreement will be Covered if such services are: (a) Medically Necessary; (b) not otherwise excluded; and (c) Prior Authorized as necessary at telephone number listed on the back of Your ID card.

A Member is entitled to benefits for health services from a Non-Participating Provider only in the case of an Emergency or if a particular Medically Necessary health service is not available from a Participating Provider. The directory of the Health Plan's Participating Providers can be found on Our website: www.chciowa.com, or a customer service representative can tell you if a Provider is Participating in either our local or national network, as applicable. However, please note that We reserve the right to make changes in Our Participating Provider network as appropriate or necessary.

When additional medical services are needed, ask if all services will be provided by the Participating Provider (including tests, x-rays, or diagnostic procedures) to ensure Coverage. If You are referred to a Specialist or hospitalization is required, BE SURE to verify that the Provider or Hospital is Participating.

2.5 Out-of-Network Exception

If You are unable to obtain necessary care from a Participating Provider then You may obtain that care from a Non-Participating Provider if You request and We approve an Exception prior to receipt of care. Exceptions to Cover services of a Non-Participating Provider may be granted when the Health Plan determines that the Medically Necessary services cannot be received within the service area.

If you would like an exception, You or Your Provider must call or submit a request and receive Health Plan approval prior to You scheduling or receiving such care. Requests for exceptions must be submitted to the Health Plan in writing, with supporting medical information. The Health Plan's medical staff will review the information submitted to determine if an exception is necessary and will notify You of the

Coverage decision. If an exception is not specifically granted by the Health Plan prior to Your receipt of the services, the Out-of-Network services will not be Covered.

2.6 Member Responsibility

You are responsible for paying any Copayments listed in Your Schedule of Benefits to Participating Providers at the time of service. Additional cost sharing amounts, such as any Coinsurance and Deductible, will be calculated and applied based on the Allowable Amount for Covered Services. The Health Plan will pay Providers the Allowable Amount reduced by any Copayment, Coinsurance or Deductible, which You are responsible for paying.

If Your Provider is Participating and the Utilization Management Program was followed, then any amount above the Allowable Amount will not be billed to You. If Your Provider is Non-Participating or the Utilization Management Program was not followed, then services will not be Covered and Your Provider will bill these amounts to You at a later time.

2.7 How to Contact the Health Plan

Throughout this Evidence of Coverage, You will find that We encourage You to contact Us for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact Us at the Customer Service telephone number on Your identification card or by calling (800) 257-4692. Members may also submit online inquiries through secure messaging by visiting Our website at www.chciowa.com.

Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Agreement.

SECTION 3: UTILIZATION MANAGEMENT

3.1 Utilization Management Program

Our Utilization Management Program is designed to assist You in receiving Medically Necessary health care in a timely and effective manner, at the

appropriate level, in the appropriate setting, and at the most reasonable cost. The Utilization Management Program is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

When You receive care from a Participating Provider, Your Provider is responsible for following the Utilization Management policies and procedures and may Prior Authorize services on Your behalf. If You use a Non-Participating Provider, You are solely responsible for obtaining Prior Authorization from Us and will be responsible to ensure that the Utilization Management policies for Prior Authorization are followed.

You are responsible for determining if Your Provider is Participating or Non-Participating and for obtaining any required Authorization either directly or through Your Provider before receiving health services.

3.2 Utilization Management Reviews

Not all medical services are Covered. Medical services must be Medically Necessary and be listed as a Covered Service under the Agreement to be covered. Utilization Management reviews are performed to determine Medical Necessity under the following circumstances:

- 3.2.1 Prospective or Pre-Service Review** - Conducting utilization review for the purpose of Prior Authorization is commonly called prospective or pre-service review. A prospective review will determine whether the requested service or admission meets Medical Necessity criteria and is Covered *before* a non-Emergency service or Hospital admission. Depending on whether Your Provider is Participating or Non-Participating, You may be responsible for contacting Us to obtain Prior Authorization.
- 3.2.2 Concurrent Care Review** – This review occurs at the time care is being rendered. When You are an inpatient in the Hospital, confined to a Nursing Facility, or receiving ongoing outpatient services, concurrent review will be conducted to determine ongoing Medical Necessity for such care.
- 3.2.3 Retrospective or Post-Service Review**- Retrospective or Post-Service utilization

review occurs for medical services that have not been Prior Authorized by the Health Plan, after services have been provided.

Following a Utilization Management review of all of the documentation provided, We will inform You and the requesting Provider, as appropriate, of Our determination. You have the right to appeal any Utilization Management Program decision according to Our Complaint and Grievance Procedures, as set forth in Section 14.

3.3 Prior Authorization Requirements

Some services and supplies require Prior Authorization before receiving that service or supply. To determine which services and supplies require Prior Authorization, please contact customer service at the number on the back of Your ID card. Because the services requiring Prior Authorization are subject to change, customer service can provide the most up to date information. In general, there are some Prior Authorization policies You should know:

- 3.3.1** You or Your Provider must request Prior Authorization from Us prior to all non-Emergency Hospital admissions or outpatient surgeries.
- 3.3.2** We request that You contact Us at least seven (7) Business Days prior to a scheduled Hospital admission or outpatient surgery or other outpatient procedures to ensure review in a timely manner.
- 3.3.3** Emergency screening and stabilization do not require Prior Authorization, however notify Us as soon as is reasonably possible. Services following stabilization may require Prior Authorization;
- 3.3.4** If You require organ or tissue transplant services, Your services and admission to a Coventry Approved Transplant Facility must be Prior Authorized.
- 3.3.5** If Your Agreement provides Coverage under a Mental Disorder and Substance-Related Disorder Rider, Prior Authorization must be obtained from the telephone number listed on Your ID card.
- 3.3.6** Failure to provide sufficient notice of to

obtain Prior Authorization when required may result in reduction or denial of benefits.

3.4 Case Management

Case Management is a voluntary program intended to provide assistance to Members with certain serious, complicated, protracted or other conditions. If a Member participates in the Case Management Program, We will coordinate with the Member, their family members and Providers to develop a Medically Necessary health care treatment plan that is intended to:

- respond to the Members' health care needs; and
- be cost-effective and promote efficient use of their Coverage.

It is the Member or their Authorized Representative's decision whether or not to participate in Our Case Management Program. Our Case Management Program does not replace the care received from the Member's Provider. The Member and his or her Physician remain in charge of the Member's health care treatment plan.

SECTION 4: SUBSCRIBER ELIGIBILITY

4.1 Subscriber Eligibility

To be eligible for Coverage as a Subscriber an individual must:

- 4.1.1** Live or work in the Service Area at least nine (9) months out of the Benefit Year unless on temporary work assignment of six (6) months or less;
- 4.1.2** Be an Employee of the Group;
- 4.1.3** Meet any eligibility criteria specified in the Group Master Contract, including any "Actively-at-Work", "Full-Time" Employee or "Part-Time" Employee or definitions;
- 4.1.4** Complete and submit to the Health Plan such applications or forms that the Health Plan may reasonably request; and
- 4.1.5** Satisfy any waiting period provided by the

Group Master Contract.

SECTION 5: DEPENDENT ELIGIBILITY

5.1 General Dependent Eligibility Requirements

To be eligible for Coverage as a Dependent, an individual must meet the following requirements:

- 5.1.1** live in the Health Plan Service Area at least nine (9) months out of the year, unless eligible as a Full-Time Student or Covered under a Qualified Medical Child Support Order;
- 5.1.2** satisfy any waiting period provided by the Group Master Contract;
- 5.1.3** complete and submit to the Health Plan such applications or forms that the Health Plan may reasonably request; and
- 5.1.4** meet any eligibility criteria specified in the Group Master Contract.

5.2 Eligible Dependents

In addition to meeting the General Dependent Eligibility requirements listed above, to be Covered as a Dependent, an individual must also be one of the following:

- 5.2.1** the lawful Spouse of the Subscriber;
- 5.2.2** an unmarried child under the Limiting Age of twenty five (25), or older if provided by the Group Master Contract:
 - a)** who is either the birth child of the Subscriber or the Subscriber's Spouse;
 - b)** who is legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
 - c)** for whom the Subscriber or the Subscriber's Spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order;

or

- d) for whom the Subscriber or the Subscriber's Spouse is the court-appointed legal guardian;

NOTE: Eligibility for such a child will continue until the first Group Renewal Date following the child's marriage or the child reaching the Limiting Age, unless the child is disabled or maintains Full-Time Student status as provided below.

5.2.3 an unmarried child of any age, if:

- a) the child has a disability and as a result, they are physically or mentally incapable of earning a living and chiefly dependent on the Member for support and maintenance;
- b) the onset of such incapacity occurred before the Limiting Age; and
- c) proof of such incapacity is furnished to Us by the Member upon enrollment or at the onset of the Dependent child's incapacity prior to reaching the Limiting Age and annually thereafter; or

5.2.4 an unmarried child of any age if:

- a) the child is both a Full-time Student and Covered as a Dependent by the Health Plan when the child reaches the Limiting Age and maintains Full-time Student status after reaching the Limiting Age; and
- b) the child submits documentation of Full-Time Student status to the Health Plan upon request and at least twice annually.

NOTE: After a child reaches the Limiting Age of twenty five (25), if the child ceases to be a Full-Time Student at any time, that child is no longer eligible even if that child becomes a Full-Time Student again at a later date.

5.3 Individuals not Eligible for Dependent Coverage

The following are not eligible for Coverage as a Dependent:

5.3.1 A Spouse or child, while on active duty in the armed forces of any country;

5.3.3 A Dependent child's legal dependent;

5.3.4 A child for whom you have only temporary custody or no legal obligation to support; or

5.3.5 A child already receiving Coverage as the Dependent of another Subscriber.

SECTION 6: ENROLLMENT

All eligible Employees of a Group and their eligible dependents may enroll with the Health Plan for Coverage under this Agreement during the Group Enrollment Period. After the Group Enrollment Period, an eligible employee or dependent may enroll only if they qualify as a new or transfer employee, under a valid waiver, or for a Special Enrollment Period as provided in section 6.4 below.

6.1 Group Enrollment Period

The Group Enrollment Period allows open enrollment for all eligible Employees and dependents for a period of thirty-one (31) days.

6.2 New or Transfer Employees

An Employee who is new or transfers into the Health Plan Service Area after the Group Enrollment Period, may enroll by submitting a Health Plan Enrollment Application within thirty-one (31) days after becoming eligible. If the Employee fails to submit a Health Plan Enrollment Application for purposes of enrolling with the Health Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he/she is not eligible to enroll until the next Group Enrollment Period.

6.3 Valid Waiver

An eligible Employee and his or her eligible dependents may enroll within thirty-one (31) days, if the employee waived Coverage under this Health Plan during the Group Enrollment Period because the employee or Dependent had other health insurance, and that health insurance was:

- 6.3.1** COBRA continuation coverage, which has since been exhausted;
- 6.3.2** Creditable coverage, that has since terminated as a result of:
 - a)** termination of employment;
 - b)** loss of eligibility due to a reduction of hours of employment;
 - c)** termination of the other health benefit plan;
 - d)** death of a Spouse;
 - e)** legal separation;
 - f)** divorce;
 - g)** loss of coverage because the Employee or dependent no longer lives or works in the HMO's service area (where applicable);
 - h)** coverage for which benefits have been exhausted after the Employee or dependent incurred a claim that met or exceeded the lifetime limit on all benefits; or
 - i)** under continuation of coverage and coverage was exhausted or terminated.

If the eligible Employee or dependent enrolls within the thirty-one (31) day period, Coverage under the Health Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for enrollment is received, unless otherwise provided by the Group Master Contract.

6.4 Special Enrollment Period

The Special Enrollment Period begins on the date when an eligible Employee gains a dependent as the result of one of the following events:

- 6.4.1** Marriage or divorce;
- 6.4.2** Birth, adoption, or placement of a child for adoption; or
- 6.4.3** Issuance of a Qualified Medical Child Support Order to the Subscriber or

Subscriber's Spouse.

The Special Enrollment period allows eligible individuals to enroll, subject to the provisions below within thirty-one (31) days of one of these events taking place, or the date such dependent Coverage is available, whichever is later. The following individuals are eligible to enroll under this provision:

6.4.4 Non-participating Employees. An Employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

6.4.5 A Non-participating Spouse. A Spouse may enroll at the time of marriage to a Subscriber, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).

6.4.6 New Dependents of Covered Employee. A child who becomes a dependent of a Subscriber as a result of marriage, birth, adoption, placement for adoption, or a Qualified Medical Child Support Order may enroll at that time. A newborn dependent automatically will be Covered from moment of birth, but must enroll and submit premium within sixty (60) days for Coverage to continue. A newly adopted child of the Subscriber will be Covered from the placement for adoption, but must be enrolled and premium submitted within sixty (60) days of the placement for Coverage to continue. If a child becomes a Dependent as a result of a Qualified Medical Support order, the Subscriber must provide Us a copy of the court order when enrolling the child.

6.4.7 New Dependents of Non-participating Employee. A child who becomes a dependent of a non-enrolled Employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled Employee is eligible for enrollment and enrolls at the same time.

An eligible Employee who qualifies for

Special Enrollment because of a new eligible dependent may enroll, subject to the provisions below, within thirty-one (31) days of the event taking place, or the date such dependent Coverage is available, whichever is later.

6.5 Notification of Change in Status

A Subscriber must notify the Health Plan, through the Group, of any changes in eligibility or enrollment status within thirty-one (31) days after the date of the event. This notification must be submitted on a written Change of Status form to Customer Service or the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, Dependent status, Medicare eligibility or Coverage by another payer. The Health Plan should be notified within a reasonable time of the death of any Member.

SECTION 7: EFFECTIVE DATES

7.1 Effective Dates

7.1.1 Enrollees During Group Enrollment Period:

An Employee who is eligible for Coverage under this Agreement, and enrolls during a Group Enrollment Period, shall be Covered under this Agreement as of the Member Effective Date or a date mutually agreed to by the Health Plan and the Group. Family members enrolled with the Employee during the Group Enrollment Period will have the same Effective Date as the Employee.

7.1.2 Newly Hired Employees:

A newly hired Employee who is eligible for Coverage shall be Covered under this Agreement as of the date that he/she first becomes eligible for Coverage so long as the Health Plan receives the Employee's completed Enrollment Form within thirty-one (31) days of the date that the Employee first became eligible for Coverage. Family members enrolled with the newly hired Employee will have the same Effective Date as the Employee.

7.1.3 Newly Eligible Employees: An Employee of the Group who transfers into the Service Area, and had been otherwise eligible for Coverage under this Agreement shall be Covered as of the first (1st) day of the month following the date that he/she first transfers into the Service Area so long as the Health Plan receives the Employee's Enrollment Form within thirty-one (31) days of the date that the Employee first become eligible for Coverage. Family members enrolled with the newly hired Employee will have the same Effective Date as the Employee.

7.1.4 Special Enrollees: An Employee and any dependents who are eligible for and enroll during a Special Enrollment Period, as described in Section 6.4, will be Covered the first day of the first calendar month following submission of a completed Enrollment Form except as specified below:

- a) Coverage of a Dependent born to a Subscriber or Dependent Spouse is effective from the date of birth for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, premature birth and routine nursery care. Coverage for a child adopted by a Subscriber or Dependent Spouse shall be effective from the earliest of the following:
 - i) The date of placement of the child for the purpose of adoption and continuing in the same manner as for other Dependent children of the , unless the placement is disrupted prior to legal adoption and the child is removed from placement.
 - ii) The date of entry of an order granting the covered person custody of the child for purposes of adoption.
 - iii) The effective date of adoption.
- b) Coverage of a Dependent eligible as a result of a Qualified Medical Child Support Order shall become effective as of the date specified in the order. If no date is specified in the order, Coverage

shall be effective as of the date the order is issued by the court.

7.1.5 Changes to Group Master Contract: If a change to the terms of the Group Master Contract, including the Group selection of the Schedule of Benefits or provision of optional benefits through a Rider, are agreed upon by Coventry and the Group, your benefits may change accordingly. Any changes to Your insurance will become effective on the date a new or revised Group Master Contract and necessary benefit documents such as the Schedule of Benefits or Riders are issued to the Group.

7.1.6 Changes to Subscriber's Employee Class: If the Group Master Contract defines more than one class or category of employee, then a Subscriber's benefits may change if they become eligible under a different employee class or category. Any such changes will become effective upon proper notification to the Health Plan and in accordance with the Group Master Contract.

7.1.7 Inpatient on the Member Effective Date: Coverage for an eligible Employee or eligible dependent who is confined as an inpatient in an Hospital, Nursing Facility or Hospice will begin on the Member Effective Date corresponding to their enrollment without regard to their inpatient status. However, if a Member is covered by a prior plan under an extension of benefits provision pursuant to state law, services or supplies that are covered, or required to be covered, under the extension of benefits will be Covered under this Agreement subject to the Agreement's Coordination of Benefits Section.

SECTION 8: COVERED SERVICES

The Health Plan Covers only those health services, supplies, drugs, and equipment that are:

- (1) listed as a Covered Service below or in an attached Rider or Amendment;
- (2) deemed Medically Necessary by Us; and
- (3) not excluded under the Exclusions and Limitations set forth in this Agreement.

Only services and treatments that meet both Our Medical Necessity criteria and are listed as a Covered Service in the Agreement will be Covered. Services and treatments listed under the Exclusions and Limitations Section are not Covered, regardless of Medical Necessity.

If You will be obtaining a service You believe to be Medically Necessary, but it is not specifically listed and not otherwise excluded, please contact Us so that We may confirm whether the service, supply, drug, or equipment is a Covered Service.

Some services require Prior Authorization. The services requiring Prior Authorization are subject to change. Your Provider may call on Your behalf, but it is ultimately Your responsibility to contact Customer Service to determine if Prior Authorization is necessary and to request Prior Authorization. In general, you should call Customer Service before scheduling:

- Outpatient surgical procedures;
- Non-Emergency hospitalizations;
- Home Health Care;
- Prosthetics and Durable Medical Equipment;
- Short-term Therapy or rehabilitation;
- Transplants;
- Outpatient Services not provided in a Physician's office;
- High Technology Diagnostics; and
- Out-of-Network services.

The following table of Covered Services is provided to assist You with determining the services and supplies that are Covered Services when determined to be Medically Necessary. This table does not provide the amount of Your cost-sharing responsibility. Please refer to Your Schedule of Benefits for any applicable Copayments, Deductibles, Coinsurance, or Maximum Benefits.

8.1 Table of Covered Services

COVERED SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY PRIOR AUTHORIZATION HAS BEEN OBTAINED		
SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections when Medically Necessary.	<u>Exclusions:</u> <ul style="list-style-type: none"> • Installation of air filters, air purifiers, air ventilation system cleaning; and • Over-the-counter allergy medications, except as Covered under an Outpatient Prescription Drug Rider.
Ambulance	Covered Service for ground ambulance to the nearest facility when ambulance travel is determined to be Medically Necessary. Covered Service for air ambulance when Medically Necessary and due to an Emergency Medical Condition.	<u>Exclusions:</u> Ambulance transportation due to the absence of other transportation on the part of the Member.
Blood and Blood Products Administration	Covered Service for administration, storage, and processing of blood and blood products in connection with Medically Necessary services.	<u>Exclusions:</u> <ul style="list-style-type: none"> • Services and associated expenses related to personal blood storage, unless associated with a scheduled surgery; • Fetal cord blood harvesting and storage; or • Whole blood and blood products replacement to a blood bank.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Breast Reconstruction	<p>Covered Service consistent with the Women’s Health and Cancer Rights Act of 1998, if You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, Coverage will be provided for:</p> <ul style="list-style-type: none"> • Reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Breast prostheses and physical complications of mastectomy, including lymphedema. <p>Reconstructive breast surgery following a mastectomy will be Covered regardless of the lapse of time since the mastectomy.</p>	<p>May require Prior Authorization.</p> <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Breast Reduction or augmentation unrelated to a Medically Necessary Mastectomy; and • Services and treatments not provided in the most cost-effective manner.
Chiropractic Services	See “Manipulative Therapy” benefit.	
Cardiac Rehabilitation Therapy	Covered Service when determined by Us to be Medically Necessary and provide significant improvement of Your condition.	<p>May require Prior Authorization.</p> <p><u>Limitation:</u></p> <p>Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits.</p> <p><u>Exclusion:</u></p> <p>Phase III therapy (unmonitored rehabilitation) is not Covered.</p>
Chemotherapy and radiation therapy	Standard chemotherapy and radiation therapy, not determined to be Experimental and Investigational.	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Colon Cancer Screening	<p>Covered Service for screening for colorectal cancer for any nonsymptomatic person fifty years of age and older.</p> <p>Such screening shall include a maximum of:</p> <ul style="list-style-type: none"> • One screening fecal occult blood test annually; • A flexible sigmoidoscopy every five years; • A colonoscopy every ten years; and • A barium enema every five to ten years. 	May require Prior Authorization.
Dental & Oral Services-Accident Only	<p>Coverage benefit limited to the Emergency treatment of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums.</p> <p>Services are Covered for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate.</p>	<p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Removal of dentiginous cysts, mandibular tori and odontiod cysts are excluded as they are dental in origin. • Removal of teeth due to an Injury, prior to radiation or for radionecrosis; • Preventive Dental & Oral services, Dental services not required as a result of an accident or otherwise mandated by state law. • Care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth; • Root canals; • Surgery for impacted teeth; • Surgery involving structures directly supporting the teeth; or • Orthodontia.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Dental & Oral Services- Anesthesia/ Hospital	<p>Medically Necessary Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges may be Covered for:</p> <ul style="list-style-type: none"> • Dependent child, who is under age five (5); • developmentally disabled; or • has a medical condition that requires care to be received in a Hospital setting. 	<p>May require Prior Authorization.</p> <p><u>Exclusion:</u> Professional fees for oral surgeons and dental Providers associated with Covered Dental-Related Anesthesia, Hospital or Ambulatory Facility services.</p>
Dermatological Services	<p>Covered Service for Medically Necessary treatment, including but not limited to, psoriasis, cystic acne, and removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.</p>	<p><u>Exclusion:</u> Services, procedures or surgeries determined to be Cosmetic.</p>

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Diabetes Treatment and Supplies	<p>Covered Service for:</p> <ul style="list-style-type: none"> • Test strips for glucose monitoring; • Urine Testing strips; • Insulin; • Injection aids, lancet and lancet devices, or syringes • Blood glucose monitors; • Outpatient self-management training and patient management; • Medically Necessary Insulin pumps and all supplies for the pump; • Insulin infusion devices; • Oral agents for controlling blood sugars; • Glucose agents and glucagon kits; • Insulin measurement and administration aids for the visually impaired; • Patient management materials that provide essential diabetes self-management information; • Podiatric appliances for the prevention of complications associated with diabetes; and • Home visits when determined to be Medically Necessary. 	<p>May require Prior Authorization.</p> <p><u>Limitations:</u></p> <p>Blood glucose monitors may be obtained from Our national vendor at a reduced price.</p> <p>If not Covered under an Outpatient Prescription Drug Rider, Coverage for blood glucose meters, lancet and lancet devices, test strips, insulin injection aids, syringes, oral agents for controlling blood sugars, and glucose agents and glucagon kits will be provided under this EOC.</p> <p>Some diabetes supplies may be Covered under Your Durable Medical Equipment benefit and subject to any limitations in the Schedule of Benefits.</p>

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Dialysis	Covered Service for hemodialysis and peritoneal services provided by participating outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance are a Covered Service.	May require Prior Authorization. <u>Limitations:</u> Some dialysis supplies may be Covered under Your Durable Medical Equipment benefit and subject to any limitations in the Schedule of Benefits.
Disposable Supplies	Not a Covered Service, except for: <ul style="list-style-type: none"> • Ostomy; • Disposable diabetic supplies; and/or • Supplies used in addition to or as part of a piece of Covered Durable Medical Equipment (DME), if the supplies are needed to ensure proper functionality of the Covered DME. 	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
<p align="center">*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.</p>		
<p>Durable Medical Equipment (DME)</p>	<p>Covered Service when determined to be Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part, and when <u>all</u> of the following circumstances apply:</p> <ul style="list-style-type: none"> • It can withstand repeated use; • It is primarily and customarily used to serve a medical purpose; • It is generally not useful to a person in the absence of illness or injury; • It is appropriate for use in the home; and • It is not otherwise Excluded under the Exclusions and Limitations Section. <p>Coverage includes, but is not limited to the following: standard wheel chairs; continuous passive motion devices after surgery; rental of the equipment for the administration of oxygen; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators).</p>	<p>May require Prior Authorization.</p> <p><u>Limitations:</u></p> <p>A Maximum Benefit May apply. Please refer to Your Schedule of Benefits.</p> <p><u>Exclusions:</u></p> <p>Replacements and repairs of durable medical equipment, unless deemed Medically Necessary by Us, are excluded. DME and Braces used to return to athletic competition or recreational sporting activities are excluded.</p>
<p>Elective Sterilization</p>	<p>Refer to “Family Planning” benefit.</p>	
<p>Emergency Services</p>	<p>Covered Services include emergency services for psychiatric and Substance-Related Disorder emergency care as described in Section 8.2 below.</p> <p>Definitions of “Emergency Service” and “Medical Emergency” are in Section 1.</p>	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Eyeglasses and Corrective Lenses	Covered Service when Medically Necessary for: <ul style="list-style-type: none"> • The first pair of corrective lenses following cataract surgery or corneal transplant; or • Gas permeable contact lenses following a corneal transplant. 	<u>Exclusions:</u> <ul style="list-style-type: none"> • Vision care and optometric services including eye examinations for refractive correction, except as specifically Covered by Rider; • Radial keratotmy; • Eyeglass frames • Laser eye surgery or similar surgery done to treat refractive error; or • Sunglasses.
Family Planning	Covered Services include: <ul style="list-style-type: none"> • sterilization for both sexes, counseling, treatment and follow-up; and • information on birth control, insertion and removal of intra-uterine devices measurement for contraceptive diaphragms, and other outpatient services. 	<u>Exclusions:</u> <ul style="list-style-type: none"> • Over-the-counter birth control methods or contraceptive devices; • Prescription contraceptives, unless an Outpatient Prescription Drug Rider is included in the Agreement. • Reversal of elective sterilization; or • Surrogate parenting.
Genetic Counseling	Covered Service for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities.	May require Prior Authorization.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Growth Hormone	Coverage is provided for growth hormone therapy for Dependent children less than 19 years of age who have been diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Health Plan.	May require Prior Authorization. <u>Limitations:</u> Medical Necessity and Experimental and Investigational reviews will apply. Please contact the Health Plan for additional information.
Health Education	Covered Service for Medically Necessary education and nutritional counseling for the treatment of: <ul style="list-style-type: none">• Diabetes only. See also: "Nutritional Counseling" benefit.	May require Prior Authorization. <u>Exclusions:</u> <ul style="list-style-type: none">• Weight reduction supplies, services, equipment, drugs, therapy and procedures;• Any costs of enrollment in a health, athletic club, personal training or fitness classes; and• Diet programs or services.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Home Health Care	<p>Covered Service when all of the following requirements are met:</p> <ul style="list-style-type: none"> • The service is ordered by a Physician; • Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; • The services are a substitute or alternative to hospitalization; • Part-time intermittent services are required; • A treatment plan has been established and periodically reviewed by the ordering Physician; • The services are Medically Necessary and Authorized for Coverage by Us; • The agency rendering services is Medicare certified and licensed by the State of location; and • The Member is home bound. 	<p>May require Prior Authorization.</p> <p><u>Limitations:</u> A Maximum Benefit or limit upon the number of visits or days may apply. Please refer to Your Schedule of Benefits.</p> <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Private duty nursing; • Custodial care; • Respite care; • Convalescent care; and • Services to help meet personal, family, or domestic needs; such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services or taking medications.
Hospice	<p>Covered Service when You are terminally ill and all of these conditions are met:</p> <ul style="list-style-type: none"> • You elect to receive care in or by a state licensed hospice Provider; • Your Provider certifies that You have a life expectancy of six (6) months or less; and • services are Authorized for Coverage by Us. 	<p>May require Prior Authorization.</p> <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Private duty nursing; • Custodial care; • Domiciliary/Residential care; • Educational services; • Respite care; and • Convalescent care.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Immunizations	<p>Children’s immunizations are Covered pursuant to the Plan’s criteria, based upon approval by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Guide to Clinical Preventative Services.</p> <p>Adult immunizations are Covered per the guidelines developed by the Center for Disease control and the U.S. Taskforce of Preventive Guidelines. Adult immunizations that may be Covered if Medical Necessity criteria is met are:</p> <ul style="list-style-type: none"> • HPV vaccine; • Flu shots; • Meningitis vaccine; or • Tetanus shot <p>Please refer to Our website for further information on Covered immunizations.</p>	<p><u>Exclusions:</u></p> <p>Immunizations for travel or employment are not Covered.</p>
Infertility	Covered Service only for the diagnosis of Infertility.	Treatment of Infertility is not Covered, except as provided by an Infertility Rider.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Inpatient Hospital	Covered Service includes: <ul style="list-style-type: none"> • Room and board; • General nursing care; • Use of equipment and supplies; • Use of operating room/recovery room/treatment room; • Semi-private room or private room when Medically Necessary; • Intensive care, coronary care unit and related Hospital services; • Anesthesia services and supplies; • Laboratory and radiology examinations; and • Medication used while inpatient. 	Non-Emergency services may require Prior Authorization. <u>Limitations:</u> Consistent with Our utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity before and during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, You and Your Provider will be notified.
Jaw Joint Disorder Treatment	Not a Covered Service, except as provided under a Jaw Joint Disorder Rider.	
Laboratory Services	Covered Services include laboratory tests, services, and materials.	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Mammograms	<p>Covered Service for routine, diagnostic, and other Medically Necessary mammograms. Coverage for low-dose screening mammogram will include:</p> <ul style="list-style-type: none"> • One baseline mammogram for a Covered woman age 35-39, or more frequently if directed by the woman's Physician • One mammogram every two years for a Covered woman age 40-49, or more frequently if directed by the woman's Physician • One mammogram every year for a Covered woman age 50 or over, or more frequently if directed by the woman's Physician. 	<p><u>Limitation:</u></p> <p>Breast CT scans and MRIs may have additional requirements for Coverage and require Prior Authorization. Please contact the Health Plan for further information.</p>
Manipulative Therapy	<p>Covered Service for manipulation of the spine or other joints and muscles by any Provider, including chiropractors, and including an initial consultation, diagnosis and treatment.</p>	<p><u>Limitations:</u></p> <p>A visit limit may apply. Please refer to Your Schedule of Benefits.</p> <p>The therapy rendered by a Chiropractor must be within the scope of their professional license.</p> <p><u>Exclusions:</u></p> <p>Massage therapy, acupuncture, neuromuscular education, and acupressure.</p>

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Maternity Services	<p>Covered Service during the prenatal and postpartum period of pregnancy and during Hospital confinement. This will include complications of pregnancy of the mother and care for the newborn child as follows.</p> <ul style="list-style-type: none"> • Inpatient Care for a mother and her newborn child is Covered for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section. • If, following a consultation between the mother and attending Physician, the mother and newborn are discharged prior to postpartum lengths of stay cited above, Coverage shall be provided for up to two (2) home health care visits, provided that the first visit shall occur within forty-eight (48) hours of discharge. 	<p><u>Limitations:</u> Notification and Authorization required if You stay beyond forty-eight (48) hours following a normal vaginal delivery and in excess of ninety-six (96) hours following a cesarean section.</p> <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • abortions, except when the life of the mother would be endangered if the fetus were carried to term or if the fetus is diagnosed to have a congenital defect incompatible with life; • Breast pumps; and • Home delivery.
Medical Complications	<p>Covered Service for:</p> <ul style="list-style-type: none"> • Complications arising from Covered Services; or • Complications arising from services received prior to the Member Effective Date, if the services resulting in the complication are services that would have been Covered. 	<p>Non-Emergency services may require Prior Authorization.</p> <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Complications that occurred when You did not follow the course of treatment prescribed by a Provider. • Complications arise from non-Covered Services. Although the requested service may be Medically Necessary, if the complication is related to or as a result of a non-Covered Service, the requested service will be denied for Coverage.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Mental Disorder, Substance-Related Disorder and Biologically Based Mental Illness Services	Non-Emergency Mental Disorder, Substance-Related Disorder, and Biologically Based Mental Illness Services are not Covered except as provided for under a separate Rider.	<p><u>Limitations:</u></p> <p>Refer to Mental Disorder, Substance-Related Disorder and Biologically Based Mental Illness Rider, if applicable, for any additional benefits and benefit restrictions.</p>
Newborn Care	<p>Covered Services will be provided from the moment of birth including treatment for diagnosed congenital defects, birth abnormalities, or prematurity.</p> <p>Delivery and related care for the newborn are Covered under the Maternity Services Benefit, which provides for Inpatient Care for both the mother and newborn for the minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section, or longer with Prior Authorization.</p>	<p><u>Limitations:</u></p> <p>An Enrollment Form and premiums must be submitted to the Health Plan to continue Coverage beyond sixty (60) days.</p> <p>Please refer to the Enrollment Section for further Newborn Coverage requirements.</p> <p>Coordination of Benefits provisions will apply to newborn benefits even if the newborn is not enrolled after the automatic Coverage period.</p> <p><u>Exclusions:</u></p> <p>The following items are not Covered:</p> <ul style="list-style-type: none"> • Food supplements such as infant formula, enteral feedings, electrolyte supplements, or donor breast milk, unless specifically Covered by Rider; • Treatment for developmental conditions; and • Treatment for feeding and eating disorders of infancy and early childhood.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Nursing Facility/Nursing Care	Covered Service only when the services are a substitute or alternative to hospitalization. Coverage includes, but is not limited to, medical supplies, equipment, drugs and biologicals ordinarily furnished by the Nursing Facility, or Hospital if no designated nursing care beds are available within a 30-mile radius.	Services may require Prior Authorization. <u>Limitations:</u> Maximum Benefits or limitations on the number of days may apply. Please refer to Your Schedule of Benefits. <u>Exclusions:</u> <ul style="list-style-type: none"> • Custodial and domiciliary care; • Residential care; • Educational services; • Rest cures; • Convalescent care; and • Respite care.
Nutritional Counseling	Covered Service for Medically Necessary education and nutritional counseling for the treatment of: <ul style="list-style-type: none"> • Diabetes only. See also: "Health Education" benefit.	Services may require Prior Authorization. <u>Exclusions:</u> <ul style="list-style-type: none"> • Weight reduction supplies, services, equipment, drugs, therapy and procedures; • Any costs of enrollment in a health, athletic club, personal training or fitness classes; and • Diet programs or services.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Occupational Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function for impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement is reasonably anticipated.	Services may require Prior Authorization. <u>Limitation:</u> A visit limit may apply. Please refer to Your Schedule of Benefits. <u>Exclusions:</u> Treatment for autism, developmental delay, sensory integration disorder and/or maintenance therapy is Excluded, unless otherwise required by state law.
Off-Label Prescription Drugs	Covered Service only for FDA approved drugs as required by state law for specific life-threatening conditions.	<u>Limitations:</u> Please contact the Health Plan for further information.
Orthotics	Covered Service for the Medically Necessary treatment of diabetes if the orthotic device: <ul style="list-style-type: none"> • Is primarily and customarily used to serve a medical purpose; • Can withstand repeated use; and • Is Authorized for Coverage by Us. 	May require Prior Authorization. <u>Limitations:</u> Only care and devices provided in the most cost effective manner available will be Covered. A Maximum Benefit may apply. Please refer to the prosthetics section of Your Schedule of Benefits. <u>Exclusion:</u> Except in the case of Medically Necessary diabetes treatment, foot orthotics are not Covered.
Oxygen	Covered Service for Medically Necessary oxygen.	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Physical Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function for impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement is reasonably anticipated.	Services may require Prior Authorization. <u>Limitation:</u> A visit limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits. <u>Exclusions:</u> Treatment for autism, developmental delay, sensory integration disorder and/or maintenance therapy is excluded, unless otherwise required by state law.
Podiatry	Covered Service for Medically Necessary treatment of diabetes only .	<u>Exclusions:</u> <ul style="list-style-type: none"> ● Removal or reduction of corns and calluses; ● Clipping of toenails; ● Treatment of flat feet; ● Fallen arches; ● Routine foot care for anything other than the Medically Necessary treatment of diabetes; and ● Chronic foot strain.

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
-------------------	--------------------------------	---------------------------

*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.

Preventive Services	<p>Covered Service, including but not limited to:</p> <ul style="list-style-type: none"> • Routine physical examination, including laboratory tests and x-rays; • Well-child care, from birth to age seven including a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels; • PSA test, one in a twelve (12) month period and digital rectal examinations, all in accordance with American Cancer Society Guidelines; • Colon cancer screening (See “Colon Cancer Screening” benefit for details); and • Well-woman care, including one pap smear in a twelve month period; and • Screening mammography (See “Mammography” benefit for details). 	<p><u>Limitations:</u></p> <p>Preventive Care does not include any service or benefit intended to treat an existing illness, injury or condition.</p> <p>Please note that some Covered Services You receive during a Preventive Care office visit may not qualify as Preventive Care under this Section.</p> <p>Please refer to Your Schedule of Benefits to determine if Preventive Services, described under the Covered Services Section of this Agreement, are exempt from any Deductible.</p>
----------------------------	---	---

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Professional Services	<p>Covered Services include:</p> <ul style="list-style-type: none"> • Outpatient Care and Office Visits— Diagnosis and treatment including: Physician services, surgical procedures and consultations with and treatment by Specialists, and services provided by other duly licensed medical professionals. • Care While Hospitalized—Including services of Physicians and ancillary medical personnel, surgical procedures, and consultation with and treatment by Specialists during hospitalization. 	
Prosthetic Devices	<p>Initial prosthetic device is a Covered Service when determined to be Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part.</p> <p>A refitting and replacement is only Covered when determined to be Medically Necessary.</p>	<p>Services may require Prior Authorization.</p> <p><u>Limitations:</u> Only care and devices provided in the most cost effective manner available will be Covered.</p> <p>Coverage for prosthetic devices may be subject to a Maximum Benefit. Please refer to Your Schedule of Benefits.</p> <p><u>Exclusions:</u> Hearing aids and cochlear implants.</p>
Pulmonary Rehabilitation Therapy	<p>Covered Service, but limited to outpatient treatment for conditions that in the judgment of a Participating Provider and Our Medical Director are subject to significant improvement of Your condition.</p>	<p>Services may require Prior Authorization.</p> <p><u>Limitations:</u> A visit limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits.</p>
Radiology	<p>Covered Service for diagnostic and therapeutic radiology services and High Technology Diagnostics, unless determined to be Experimental or Investigational.</p>	<p>High Technology Diagnostics may require Prior Authorization.</p>

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Reconstructive Surgery	Covered Service for: <ul style="list-style-type: none"> • Repair of disfigurement resulting from an injury; • Reconstruction incidental to a Medically Necessary surgery; • Surgery that substantially improves functioning of any malformed body part; and • Correction of a congenital defect for Dependent children, unless specifically Excluded elsewhere in this Agreement. Breast Reconstructive surgery is Covered for post mastectomy patients. (See “Breast Reconstruction” benefit.)	Services may require Prior Authorization. <u>Exclusions:</u> <ul style="list-style-type: none"> • Panniculectomy resulting from weight loss; • Surgery determined to be Cosmetic; • Complications as a result of Cosmetic surgery; or • Scar Revisions deemed to be Cosmetic.
Sleep Studies	Covered Service when performed in an accredited facility.	Services may require Prior Authorization.
Speech Therapy	Covered Service when determined to be Medically Necessary to restore speech loss or speech impairment due to trauma, stroke, a surgical procedure, child’s hearing condition or other acute condition, and significant improvement is expected.	Services may require Prior Authorization. <u>Limitations:</u> A visit limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits. <u>Exclusions:</u> Speech therapy for autism, developmental delay, or sensory integration disorder in children are excluded unless otherwise required by law.
Spinal Manipulation	See “Manipulative Therapy” benefit.	

**COVERED SERVICES OR SUPPLIES WHEN DETERMINED
BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY
PRIOR AUTHORIZATION HAS BEEN OBTAINED**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	EXCLUSIONS & LIMITATIONS*
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Surgical Services	Covered Service when Medically Necessary, unless otherwise excluded under the Exclusions and Limitations section. For oral surgery services, see “Dental and Oral Services- Accident Only” benefit.	Services may require Prior Authorization. <u>Exclusions:</u> • Cosmetic surgery; and • Bariatric, lap band, gastric bypass or other weight loss surgery.
Temporo-mandibular Joint Syndrome (“TMJ”)	See “Jaw Joint Disorder” Benefit.	
Therapeutic Injections and IV Infusions	Covered Service when FDA-approved and Medically Necessary. Therapeutic Injections and IV Infusions are Covered when administered in an inpatient setting, an outpatient facility, or Provider’s office.	<u>Limitations:</u> Certain Self-Injectable medication may be Covered by an Outpatient Prescription Drug Rider and are excluded from the medical benefit. Therapeutic Injections are subject to the Health Plan’s preferred list and substitution by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan. Services other than chemotherapy and certain Self-Injectable medication may require Prior Authorization.
Transplants	See Section 8.4.	Services may require Prior Authorization. <u>Limitations:</u> Transplants must be rendered by a Coventry Transplant Center of Excellence.
Urgent Care	Covered Service	

8.2 Emergency Benefits

In the event You experience an Emergency Medical Condition, contact Your Physician before receiving services if time permits. If You are unable to contact Your Physician, seek help immediately at the nearest Participating Hospital, Participating Physician's office or other Participating emergency facility. If You are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would create a danger to Your health, You should obtain medical attention from the nearest Hospital or through 911 Emergency Services (where available).

Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and do not require Prior Authorization. Services rendered by non-Participating Providers or in non-Participating facilities will not be Covered if You remain in a non-participating facility after We have made the appropriate arrangements for transfer to a Participating facility.

8.2.1 What is an Emergency Medical Condition?

An Emergency or Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention, to result in:

- a) serious jeopardy to the health of the individual (or unborn child) or in the case of a behavioral condition, placing the health of the individual or others in serious jeopardy;
- b) serious impairment to bodily function;
- c) serious impairment to any bodily organ or part; or
- d) serious disfigurement.

An Emergency Medical Condition includes, but is not limited to, heart attacks, strokes, poisoning, seizures,

severe bleeding and psychiatric emergency care.

8.2.2 What You should do if You experience an Emergency Medical Condition?

All of the procedures listed below should be followed to ensure that You will not be liable for the cost of the Emergency Services.

- a) When an Emergency occurs, seek medical attention immediately. Notify Us within twenty-four (24) hours or the next business day, circumstances permitting, or as soon as reasonably possible.
- b) In the event a Member seeks Emergency Services and, if deemed necessary in the opinion of the emergency health care Provider responsible for the Member's Emergency care and treatment and, if warranted by his/her evaluation, the emergency Provider may initiate necessary intervention to stabilize the condition of the Member without seeking or receiving prospective Authorization from the Health Plan.

8.3 Mental Disorders, Substance-Related Disorders, and Biologically Based Mental Illness Services

The Health Plan Covers Mental Disorder, Substance-Related Disorder, and Biologically Based Mental Illness services to the extent listed on any Mental Disorder and Substance-Related Disorder Rider attached to this Policy. The Health Plan may contract with an outside vendor to coordinate, determine Medical Necessity of, administer Appeals and Grievances, and Prior Authorize the treatment of all Biologically Based Mental Illness, Mental Disorder, and Substance-Related Disorder. Any contracted vendor and its telephone number will be listed on Your ID card and in the provider directory.

If You have any questions about Your Mental Disorder Substance-Related Disorder Coverage or

the appropriate way to access Coverage, please either contact the Health Plan at (800) 257-4692 or our contracted vendor.

8.4 Transplant Services

Services related to Medically Necessary organ and tissue transplants are Covered when approved by Us and must be rendered by a Coventry Approved Transplant Center. **All transplant related services, including evaluation, require Prior Authorization.**

Donor screening tests are Covered and may be subject to a Maximum Benefit as provided in Your Schedule of Benefits.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-Covered individual, when the recipient is a Member, will be Covered for the duration of the contract of the Member when approved by Us.

The cost of any care, including complications, arising from an organ donation by a Member when the recipient is not a Member is excluded.

SECTION 9: EXCLUSIONS AND LIMITATIONS

9.1 GENERALLY EXCLUDED SERVICE /ITEMS

Generally excluded services/items:

- 9.1.1** Any service, supply, equipment, drug or procedure that is not provided or arranged in accordance with Our Utilization Management Program;
- 9.1.2** Any service, supply, equipment, drug, or procedure that we determine is not Medically Necessary and delivered in the most cost effective manner;
- 9.1.3** Any service, supply, equipment, drug or procedure that We determine to be Experimental and Investigational;
- 9.1.4** Any service, supply, equipment, drug, or procedure that is not listed as a Covered Service;

- 9.1.5** Any service, supply, equipment, drug or procedure that is required directly or indirectly as a result of receiving a non-Covered Service, such as medical complications of a non-Covered Service;
- 9.1.6** Any service, supply, equipment, drug, or procedure for which You have no financial liability or that was provided at no charge;
- 9.1.7** Any service, supply, equipment, drug, or procedure furnished under or as part of a study, grant, or research program;
- 9.1.8** Any service, supply, equipment, drug, or procedure rendered or utilized as a result of injuries sustained during or sickness resulting from the commission of an illegal act;
- 9.1.9** Medical services required while a member is incarcerated, or in the custody of law enforcement personnel;
- 9.1.10** Court-ordered services or services that are a condition of probation or parole;
- 9.1.11** Any services or supplies provided which are not within the scope, licensure or certificate of the Provider;
- 9.1.12** Care rendered to a Member by a Provider with the same legal residence as the Member and/or a person who is part of the Member's immediate family, including spouse, brother, sister, parent, step-parent, child or step-child;
- 9.1.13** Any services provided by a licensed Provider of health care which are not medical services or which may be performed by non-medical personnel;
- 9.1.14** Services or supplies for the treatment of an occupational injury or illness that is paid under Workers' Compensation laws;
- 9.1.15** Any administrative or overhead fees, clinic charges, or charges associated with ownership and/or operation of the facility of any Provider practice;

- 9.1.16 Charges resulting from Your failure to appropriately cancel a scheduled appointment;
 - 9.1.17 Those services otherwise Covered under the Agreement, but rendered after the date a Member's Coverage under the Agreement terminates, including services provided after the date of termination for medical conditions arising prior to the date a Member's Coverage terminates;
 - 9.1.18 Services that are paid by, or recovered amounts specifically for, medical expenses from a third party or insurance carrier;
 - 9.1.19 Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan; and
 - 9.1.20 Services the Member is entitled to under Medicare Part B even if the Member is not enrolled.
- 9.2 SPECIFICALLY EXCLUDED SERVICES**
- Specifically excluded services/items include:
- 9.2.1 Abortions - except when the life of the mother would be endangered if the fetus were carried to term or if the fetus is diagnosed to have a congenital defect incompatible with life;
 - 9.2.2 Acupuncture or acupressure;
 - 9.2.3 Allergies – Over-the Counter or Non-Physician allergy services or associated expenses relating to an allergic condition including, but not-limited to, installation or air filters, air purifiers, or air ventilation system cleaning;
 - 9.2.4 Alternative Therapies- including but not limited to aroma therapy, light therapy or massage;
 - 9.2.5 Ambulance services for non-Emergencies;
 - 9.2.6 Audiometric testing;
 - 9.2.7 Batteries for all devices including wheelchairs and hearing aids;
 - 9.2.8 Behavior modification;
 - 9.2.9 Behavioral Conditions – Conditions not attributable to a Mental Disorder described in the Diagnostic and Statistical Manual Published by the American Psychiatric Association as “V” codes, which are used when some circumstance or problem that influences the Member's health status is present, but is not by itself, a current illness or injury. Such conditions include, but are not limited to, relational problems, anti-social behavior, academic problems and phase-of-life problems;
 - 9.2.10 Biofeedback;
 - 9.2.11 Blood Storage – Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Fetal cord blood harvesting and storage is not a Covered Service;
 - 9.2.12 Boot camps;
 - 9.2.13 Braces and supports needed for athletic participation or employment;
 - 9.2.14 Breast pumps;
 - 9.2.15 Cochlear implants, including follow-up care, such as speech therapy, related to an implant procedure;
 - 9.2.16 Cognitive rehabilitation;
 - 9.2.17 Cosmetic services and surgery and the complications incurred as a result of those services and surgeries, including but not limited to: breast augmentation or reduction not associated with cancer of the breast; removal of skin lesions, unless the lesions interfere with normal body functions or malignancy is suspected; salabrasion, laser surgery, blepharoplasty

- or chemosurgery;
- 9.2.18** Custodial and domiciliary care, residential care, or protective and supportive care including, but not limited to, educational services, rest cures, convalescent care, respite care, or any health-related services that do not seek to cure and are provided during periods when the medical condition of the patient is not changing or that do not require continued administration by trained medical personnel;
 - 9.2.19** Day care;
 - 9.2.20** Delirium, dementia, amnesia or cognitive disorders;
 - 9.2.21** Dental care, appliances, implants, crowns, bridges, dentures, or other prosthetic devices, dental restorative care, periodontal care, treatment of impacted wisdom teeth, orthognathic surgery, or X-rays, including, but not limited to, any Physician services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums;
 - 9.2.22** Diet programs and supplies- see also: “weight reduction”;
 - 9.2.23** Disposable take home items or consumable outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, food, food supplements, and food replacements, and special food items, unless they are specified as Covered;
 - 9.2.24** Driving tests or exams;
 - 9.2.25** Durable Medical Equipment, that does not qualify as Medically Necessary, such as: bed boards; Patient lifts, including but not limited to chair lifts, seat lifts, car lifts, shower lifts, toilet lifts and bed lifts; chairs and rails; over-bed tables; wheelchair trays and flotation devices; stethoscopes; blood pressure gauges; orthotics;
 - 9.2.26** Dynamic Orthotic Cranioplasty (DOC) Bands, Cranial Orthosis, Molding Helmet Therapy, or surgical treatment of deformational plagiocephaly;
 - 9.2.27** Educational testing or psychological testing, including but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training, unless part of a treatment program for Covered Services;
 - 9.2.28** Enteral Feeding Food supplement – The cost of outpatient enteral tube feedings or formula and supplies.
 - 9.2.29** Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage, or functional capacity;
 - 9.2.30** Exercise equipment, rental or purchase;
 - 9.2.31** Eyeglass frames and lenses and contact lenses, except for the initial placement of lenses immediately after cataract surgery;
 - 9.2.32** Eye Surgery or Services, including but not limited to, radial keratotomy, laser eye surgery or similar surgery done to treat refractive error, and eye exercises;
 - 9.2.33** Food or food supplements, including but not limited to, infant formulas;
 - 9.2.34** Foot care, including but not limited to removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, foot orthotics, chronic foot strain, orthopedic shoes; shoe inserts and arch supports; heel lifts, cups and pads, except for the Medically Necessary treatment of diabetes;
 - 9.2.35** Gastric bypass surgeries (both laparoscopic and open), including but not limited to: Roux en-Y procedures,

- jejunoileal bypass, gastric banding, lap banding, biliopancreatic bypass, gastroplasty, and gastric balloon;
- 9.2.36** Hair analysis such as evaluation of alopecia or age-related hair loss, hair prostheses, wigs and transplants;
- 9.2.37** Health and Athletic Club membership – Any costs of enrollment in a health, athletic club, personal training or fitness classes;
- 9.2.38** Hearing aids or devices, including the cost and fitting;
- 9.2.39** Home services to help meet personal, family, or domestic needs; such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services or taking medications;
- 9.2.40** Humidifiers, de-humidifiers, air-conditioners, space heaters, or any other equipment or service used in altering air quality or temperature;
- 9.2.41** Hypnotherapy;
- 9.2.42** Immunizations for travel or employment;
- 9.2.43** Infertility services, supplies, equipment, procedures and drugs relating to: artificial insemination with donor semen; the conception and pregnancy of surrogate mothers; surrogate childbirth, egg or sperm donation, cryopreservation, in vitro fertilization, and storage of sperm, eggs and embryos; sterilization reversal, unless otherwise Covered by a Rider;
- 9.2.44** Learning disabilities treatment;
- 9.2.45** Long-term care and all services provided by such facilities;
- 9.2.46** Maintenance treatment or therapy that is not part of an active treatment plan intended to or reasonably expected to improve the Member's sickness, injury, or functional ability;
- 9.2.47** Marriage or relationship counseling; family counseling; bereavement counseling; vocational or employment counseling;
- 9.2.48** Massage therapy;
- 9.2.49** Mental Disorders, except as provided in a Rider;
- 9.2.50** Mental retardation and disorders relating to: learning, motor skills and communication;
- 9.2.51** Newborn home delivery;
- 9.2.52** Motorized scooters or motorized vehicle customization;
- 9.2.53** Naturopathy;
- 9.2.54** Non-Prescription Drugs and Medications - Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded, unless Covered by an optional Outpatient Prescription Drug Rider;
- 9.2.55** Oral Surgery required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, involving removal of symptomatic bony impacted third molars;
- 9.2.56** Orthodontia and related services;
- 9.2.57** Orthotic Appliances and Prosthetic Devices – No coverage is provided for the repair or replacement of cranial molding helmets, banding, and anything that changes the shape of the head, mechanical organ replacement devices (such as mechanical hearts or left ventricular assist devices); orthopedic shoes and other supportive devices for the feet; dentures; splints and braces (unless they are used instead of casts), repair or replacement required because the device is lost, misplaced, misused or stolen; or

- prosthetics specifically intended for sports or occupational purposes. We do not Cover the replacement, repair or maintenance of any prosthetic item or device that is not Covered;
- 9.2.58** Over-the-counter (OTC) supplies that do not require a prescription to be dispensed, including but not limited to ACE wraps, elastic supports, finger splints, Orthotics, braces, aspirin, antacids, cervical collars and pillows, herbal products, medicated soaps, food supplements, and bandages;
- 9.2.59** Personal comfort and convenience items such as but not limited to, television, telephone, tissue, razor, toothbrush, toothpaste, barber or beauty services;
- 9.2.60** Phone consultations, internet and e-mail consultations;
- 9.2.61** Prescription Drugs and Medications— Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this EOC or as specifically provided in an optional Outpatient Prescription Drug Rider;
- 9.2.62** Prosthetic items and devices, except for those items specified as Covered, including but not limited to: Cosmetic prostheses (except for breast prostheses prescribed following a mastectomy for breast cancer or breast disease); repair or replacement required because the device is lost, misplaced, misused or stolen; or prosthetics specifically intended for sports or occupational purposes. We do not Cover the replacement, repair or maintenance of any prosthetic item or device that is not Covered.
- 9.2.63** Private duty nursing;
- 9.2.64** Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable;
- 9.2.65** Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school;
- 9.2.66** Scar or tattoo removal or revision procedures;
- 9.2.67** Sexual dysfunction aids and treatment, including Penile prostheses, sex counseling or therapy, unless the aid or treatment is specifically Covered under an Outpatient Prescription Drug Rider;
- 9.2.68** Sex transformation services –regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Hormonal support for sex transformation is also excluded;
- 9.2.69** Smoking cessation;
- 9.2.70** Substance-Related Disorders, except a provided by Rider;
- 9.2.71** Surgery performed solely to address psychological or emotional factors;
- 9.2.72** Temporomandibular Joint Disorder (“TMJ”) is excluded unless a Jaw Joint Disorder Rider has been purchased;
- 9.2.73** Transplant services, and any related conditions or complications, for a Member who is donating an organ or tissue when the recipient is not a Member;
- 9.2.74** Travel expenses, other than Medically Necessary transportation Authorized for Coverage by Us;
- 9.2.75** Vax-D therapy;
- 9.2.76** Vision care and optometric services, including eye examinations for refractive correction not provided for in a Supplemental Benefit Rider; Eye exercises and therapy; fitting or cost of visual aids; and eye glasses and corrective lenses, except as necessary for the initial placement of corrective or contact lenses following cataract surgery or corneal

transplant performed while a Member of the Plan;

9.2.77 Vocational therapy;

9.2.78 War related sickness, injury, and services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran Administration services and for which facilities are reasonably accessible to You;

9.2.79 Weight reduction supplies, services, equipment, drugs, therapy and procedures, including but not limited to, diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature; and

9.2.80 Work hardening programs.

SECTION 10: CLAIMS AND REIMBURSEMENT

10.1 Notice of Claims

If You presented Your identification card to a Participating Provider, You are not required to notify Us of proof of loss. If You did not present Your identification card and did not assign benefits to the Participating Provider, or if You received services from a Non-Participating Provider after receiving Prior Authorization from Us, You should contact Our customer service center at (800) 257-4692 to obtain the appropriate forms. We will provide You with the forms for filing proof of loss within fifteen (15) days from the date of Your request. You may also visit Our member services page on the internet at: www.chcIowa.com. If You do not receive these forms, We will accept Your written description of the loss as proof of loss.

10.2 Proof of Loss

Itemized statements of medical service provided must be furnished to Us within ninety (90) days after the date of such service. Failure to furnish such statements within ninety (90) days shall not

invalidate or reduce any claim if it were not reasonably possible to provide the statements within ninety (90) days. Except in the absence of legal capacity, bills will not be accepted later than one (1) year after the date of service.

10.3 Claims Payment

When services are rendered by a Participating Provider, payment will be made to the Provider for services rendered.

If services are rendered by a Non-Participating Provider and approved by Us, benefits will be paid directly to the Non-Participating Provider unless payment has been made by You and is indicated as such on the claim form, invoice or statement submitted.

We reserve the right to allocate any financial penalty, Deductible, Copayment and balance remaining after Coinsurance to any individual or assignee. Such action will be binding on You and Your assignees.

10.4 Physical Examination

In the event of a question or dispute concerning Coverage during the pendency of a claim, we may reasonably require that a Member be examined at Our expense by a Participating Provider acceptable to Us.

SECTION 11: COORDINATION WITH OTHER COVERAGE (COORDINATION OF BENEFITS-COB)

11.1 Coordination With Other Plans

This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some

expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of its total Allowable Expense.

11.2 Definitions of Terms Used in this Section

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

a) “Plan” includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group of individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

11.2.2 “We/Us/Our” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from Our Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

11.2.3 The order of benefit determination rules determine whether We are a “Primary” Plan or “Secondary” Plan when You have health care coverage under more than one Plan.

When We are Primary, Our benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When We are Secondary, Our benefits are determined after those of another Plan and may be reduced so that all Plan benefits do not exceed 100% of the total Allowable Amount.

11.2.4 “Allowable Expense” means a health care service or expense including any Deductibles, Coinsurance and

Copayments, that are covered, at least in part by any Plan covering You. When a Plan provides benefits in the form of service, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering You or Your Covered Dependent is not an Allowable Expense. In addition, an expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

The following are examples of expenses or services that are **not** Allowable Expenses:

- a) The difference between the cost of a semi-private room in the Hospital and a private room, is not an Allowable Expense, unless one of the Plans provides benefits for private Hospital room expenses.
- b) If a Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- c) If a Member is covered by two or more Plans that calculate benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- d) If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable

Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits

- e) The amount of any benefit reduction by the Primary Plan because a Member does not comply with the Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider arrangements.

11.2.5 "Closed Panel Plan" is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.

11.2.6 "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

11.3 Order of Benefit Determination Rules

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

11.3.1 The Primary Plan pays or provides its benefits according to its terms of coverage without regard to the benefits of any other Plan.

11.3.2 Except for supplemental coverage as described in the following paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary,

unless the provisions of both Plans state that the complying Plan is Primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

11.3.3 A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

11.3.4 Each Plan determines its order of benefits using the first of the following rules that apply:

a) **Non-Dependent or Dependent.** The Plan that covers the Member other than as a dependent, for example as an employee, member, subscriber, or retiree is Primary and the Plan that covers the Member as a dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Member as a dependent; and Primary to the Plan covering the Member as other than a dependent (e.g. a retired Employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, subscriber or retiree is Secondary and the other Plan is Primary.

b) **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan is determined as follows:

i. For a dependent child whose

parents are married or are living together, whether or not they have ever been married:

- The Primary Plan is the Plan of the parent whose birthday falls earlier in the year; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

ii. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Benefit Years after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision of subparagraph (i) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits

for the child are as follows:

- The Plan covering the Custodial Parent;
 - The Plan covering the Spouse of the Custodial parent;
 - The Plan covering the non-Custodial Parent; and then
 - The Plan covering the Spouse of the non-Custodial Parent.
- iii. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.
- c) **Active Employee, Retiree, or Laid-off Employee.** The Plan that covers a Member as an active employee who is neither laid off nor retired, is Primary. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a Member is the dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- d) **COBRA or State Continuation Coverage.** If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by federal or state law is covered under another Plan, the Plan covering the Member as an Employee, Member, subscriber or Retiree or covering the person as a dependent of an Employee, Member, subscriber or Retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does

not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

- e) **Longer or Shorter Length of Coverage.** The Plan that covered the Member as an Employee, Member, Subscriber or Retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than We would have paid had We been Primary.

11.4 Effect On The Benefits of this Health Plan

11.4.1 When We are the Secondary Plan, We may reduce Our benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses owed by Us. In determining the amount to be paid for any claim, when We are the Secondary Plan, We will calculate the benefits We would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under Our Plan that is unpaid by the Primary Plan. We may then reduce Our payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed Our total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

11.4.2 If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB

shall not apply between that Plan and other Closed Panel Plans.

11.5 Coordination of Benefits with Medicare

11.5.1 Active Employees and Spouses Age 65 and Older

If an Employee is eligible for Medicare and works for a Group with fewer than 20 Employees for each working day in each of 20 or more calendar weeks in the current or preceding Benefit Year, then Medicare will be the primary payer. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis.

If an Employee works for a Group with more than 20 Employees for each working day in each of 20 or more calendar weeks in the current or preceding Benefit Year, the Health Plan will be primary. However, an Employee may decline Coverage under this Health Plan and elect Medicare as primary. In this instance, this Health Plan, by law, cannot pay benefits secondary to Medicare for Medicare Covered Services.

You will continue to be Covered by this Health Plan as primary unless You (a) notify Us, in writing, that You do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

11.5.2 Failure to Enroll in Medicare Part B

If a Member or Spouse is eligible for Medicare part B, We will subtract the Medicare Part B benefits available whether or not the Member or Spouse has enrolled in Medicare Part B. This means that the amount of benefit that would have been received under Medicare Part B will be subtracted from the billed amount and We will pay the remainder up to our Allowable Expense for the claim, subject to any applicable deductible or coinsurance.

11.5.3 Disability

If You are under age 65 and eligible for Medicare due to disability, and currently employed by a Group with fewer than 100 Employees, then Medicare is the primary payer. This Health Plan will pay benefits on a secondary basis.

If You are age 65 or older and actively work for a Group with at least 100 Employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) this Health Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

11.5.4 End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be the Primary Plan for the first 30 months.

11.5.5 Coordination of Benefits for Retirees (if applicable)

If You are retired and You or one of Your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Evidence of Coverage will be paid after:

- a.) Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- b.) Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been covered by Medicare; or
- c.) Amounts paid under all other plans in which You participate.

11.6 Right of Recovery

If the amount of the payments made by Us is more

than should have been paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Individual. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

11.7 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts necessary or give them to other organizations or persons for the purpose of applying these rules and determining the benefits payable under this Plan and other Plans covering the person claiming benefits. We do not need to inform, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must give Us any facts necessary to apply these rules and determine benefits payable.

11.8 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan and We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash valued of the benefits provided in the form of services.

SECTION 12: TERMINATION OF COVERAGE

12.1 Termination of Coverage by Group

The Group shall have the right to terminate this policy as specified in the Group Master Contract. Such termination shall be effective on the last day of the month in which such notice is received by Us, unless otherwise specified in the Group Master Contract.

12.2 Termination of Coverage by Us

We may terminate Coverage upon the occurrence of any one of the following events:

- 12.2.1** At least thirty-one (31) days notice of termination of Your Coverage if We determine that You no longer meet the eligibility requirements set forth in this Agreement, including the Group Master Contract and the Evidence of Coverage. Such eligibility requirements may include, but are not limited to, living outside the Service Area for a period longer than permitted under this Agreement.
- 12.2.2** At least thirty-one (31) days notice of the termination of Your Coverage due to the nonpayment of Premiums to Health Plan or supplemental charges required for Hospital or other medical services(e.g., Copayments, Coinsurance, Deductibles). In the case of termination due to nonpayment of Premium, the termination shall become retroactively effective on the day after the last day for which Premiums have been paid in full for the entire Group. Furthermore, You will be responsible for the cost of all services rendered as of the termination date. In the case of termination due to failure to pay supplemental charges, the termination shall become effective on the date stated in the written notice, which date shall be on or after the 30th day following the date of the notice;
- 12.2.3** Upon the termination or non-renewal of the Group Master Contract by the Group;
- 12.2.4** Immediately upon Your receipt of written notice of Your termination or rescission, if You participate in fraudulent or criminal behavior, including but not limited to:
 - a) Performing an act or practice that constitutes fraud or an intentional misrepresentation of material fact including, but not limited to, using Your identification card to obtain goods or services which are not prescribed or

ordered for You or to which You are otherwise not legally entitled.

- b) Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.
- c) Threatening or perpetrating violent acts against the Health Plan, a Provider, or an Employee of the Health Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
- d) Knowingly misrepresenting or giving false information on any Enrollment Form which is material to the Health Plan's acceptance of such application.

12.3 Effect of Termination

- 12.3.1 Identification cards are the property of the Health Plan and , upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- 12.3.2 Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Health Plan's Grievance and Complaint procedures. The Health Plan may not terminate this Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.
- 12.3.3 If You receive services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

- 12.3.4 Under certain circumstances, You may be eligible for continuation of Coverage benefits or to convert to another policy as described in the Continuation, Conversion, and Extension of Benefits Section.

12.4 Certificates of Creditable Coverage

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any creditable Coverage began and ended.

12.5 Notification of Termination

All notifications by the Health Plan of termination shall be in writing and shall state the reasons for such action.

SECTION 13: CONTINUATION, EXTENSION AND CONVERSION, OF COVERAGE

13.1 Introduction

State and Federal laws provide several options to continue insurance if Coverage under this Agreement is terminated. State and Federal laws also provide protections for Employees who lose their Actively-at-Work status, to continue eligibility or reinstate Coverage. State law may also provide for conversion to an individual health plan that does not require underwriting.

Sometimes, an individual is eligible for more than one of these protections at a time. If an individual is eligible for an extension of Coverage for more than one reason, the longest period of extension will apply. The extensions of Coverage cannot be added together to extend Coverage for a longer period of time, but will run concurrently. Similarly, if a Covered Individual qualifies for more than one type of Continuation Coverage, they will run concurrently from the date of the first qualifying event rather than being applied one after the other.

In the event that a Covered Individual qualifies for an extension of Coverage, such as an extension due to their status as a Hospital inpatient, the right to

continuation of Coverage must be exhausted before extension rights will apply.

In the event that a Covered Individual qualifies for continuation of coverage, those rights must be exhausted before any conversion coverage rights will apply.

If more than one qualifying event occurs, only the first event applies for purposes of determining eligibility for continuation coverage. The occurrence of a second event does not start a new or second period of continuation.

13.2 Continuation Coverage Under COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA shall apply only to Groups that are subject to the provisions of COBRA. Members should contact the Group's plan administrator to determine if he or she is eligible to continue Coverage under COBRA.

COBRA for Members who selected COBRA under a prior plan which was replaced by Coverage under this Agreement shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 13.6 below.

In no event shall the Health Plan be obligated to provide continuation Coverage to a Member if the Group or its designated plan administrator fails to perform its responsibilities as defined by federal law. These responsibilities include, but are not limited to, notifying the Member in a timely manner of the right to elect COBRA and notifying Us in a timely manner of the Member's election of continuation Coverage.

The Health Plan is not the Group's designated plan administrator and does not assume any responsibilities of a plan administrator pursuant to federal law.

This explanation is not a legal opinion, but merely a general summary of continuation of Coverage rights under COBRA. The Group is responsible for any administration of COBRA Coverage, if applicable. The Internal Revenue Service may change or amend COBRA from time-to-time.

13.3 Eligibility for Continuation Coverage Under COBRA

If a Member's Coverage would otherwise terminate, because of one of the following qualifying events, he or she is entitled to continue Coverage. Additional qualifying events may apply to Dependents only. Those qualifying events are listed in Section 13.5. A Member may elect the same Coverage that he or she had at the time of one of the following qualifying events:

13.3.1 Termination of the Subscriber from employment with the employer or reduction of hours, for any reason other than gross misconduct;

13.3.2 Reduction in the Subscriber's scheduled work hours (e.g., change from full-time to part-time, lay off, leave of absence, etc.);

13.3.3 The Subscriber's notification to the employer of the intent not to return to work, either during or after a Family Medical Leave Act approved leave; or

13.3.4 The Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is a qualifying event only if there is a substantial elimination of Coverage within one (1) year before or after the date the bankruptcy was filed.

13.4 Election Period and Premium Requirements for Continuation Coverage Under COBRA

The Member must notify the Group's designated plan administrator within sixty (60) days of his or her divorce, legal separation or loss of eligibility as an Enrolled Dependent. Continuation must be elected by the later of sixty (60) days after the Member's qualifying event occurs, or sixty (60) days after the Member receives notice of the continuation right from the Group's designated plan administrator.

An employer may require a Member whose Coverage was terminated due to a qualifying event to pay the full cost of the COBRA Coverage. The Premium

may not exceed 102% of the Premium for similarly covered Employees. The Member must pay the initial Premium due to the Group's designated plan administrator on, or no later than, the forty-fifth (45th) day after electing COBRA continuation.

13.5 Length of Coverage Under COBRA

Coverage may be continued for Subscribers and Dependents for up to eighteen (18) months. If the Subscriber is Totally Disabled, at the time of the qualifying event, Coverage may be extended for up to twenty-nine (29) months.

Coverage for Dependents may be continued for up to thirty-six (36) months for the following qualifying events:

- 13.5.1** Death of the Subscriber;
- 13.5.2** Divorce or legal separation of the Subscriber;
- 13.5.3** Loss of eligibility by a Dependent child as a result of reaching the Limiting Age; or
- 13.5.4** Entitlement of the Subscriber to Medicare benefits.

13.6 Termination of Continuation Coverage Under COBRA

Continuation Coverage under COBRA will end upon the first of the following to occur:

- 13.6.1** The date the maximum continuation period applicable is reached;
- 13.6.2** failure to make payment of the Premium when due;
- 13.6.3** The date coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any Pre-Existing condition of the Plan Member, continuation shall end on the date such limitation or exclusion ends. The other Group health coverage shall be primary for all medical services except those services which are subject to the Pre-Existing condition limitation or exclusion;
- 13.6.4** The date the Member becomes entitled to Medicare, except that this shall not apply

in the event the Member's Coverage was terminated because the Group filed for bankruptcy, in accordance with qualifying event described in Section 13.3 of this Agreement; or

- 13.6.5** The date the Group Master Contract or entire Agreement ends.

13.7 Certificates of Creditable Coverage

Certificates of Creditable Coverage will be sent by the Health Plan to all Members who lose Coverage under the Agreement. The following events trigger Certificates of Creditable Coverage Certificates to be sent:

- 13.7.1** Upon a loss of Coverage, for any reason, under a plan, including a COBRA qualifying event;
- 13.7.2** Upon loss of COBRA continuation coverage; or
- 13.7.3** At any time upon an individual's request within twenty-four (24) months after Coverage under the Agreement ends.

13.8 Iowa Continuation Coverage

Subscribers and eligible Dependents whose Coverage under this Agreement would otherwise terminate because of the Subscriber's termination of employment may elect to continue Coverage. To continue coverage, the Subscriber must have been continuously insured under the Agreement for the three consecutive months prior to termination of employment.

Election of such coverage, along with payment in full of the first monthly Premium, must be made within ten (10) days after the Member's receipt of notice of continuation rights from the employer; in no event, however, can such election be made more than thirty-one (31) days after the date of termination.

A Dependent may be eligible for Iowa Continuation, even if the Subscriber does not elect continuation, under one of the following conditions:

- 13.8.1** death of the Subscriber;
- 13.8.2** A Spouse or other Dependent who is

determined to be the subject of abuse when Coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abusers Coverage has terminated voluntarily or involuntarily.

13.9 Termination of Iowa Continuation Coverage

Iowa continuation coverage shall continue until the first of the following occurs:

- 13.9.1** Nine (9) months after the date the Member's Coverage would otherwise have terminated because of termination of the Subscriber's employment.
- 13.9.2** The Member becomes eligible for Medicare;
- 13.9.3** The Member becomes eligible for another group health insurance plan or uninsured arrangement, unless the Member was covered by such other arrangement immediately prior to termination;
- 13.9.4** If the Member fails to make timely payment of Premium when due;
- 13.9.5** If the Member is a former Spouse, upon the former Spouse's remarriage;
- 13.9.6** The date the Group Master Contract is terminated.

13.10 Extension of Coverage if a Member is an inpatient in a Hospital or Nursing Facility

The Health Plan will continue to provide Covered Services if the Group Master Contract terminates while a Member is an inpatient in a Hospital or Nursing Facility. *Services will be provided only for the specific medical condition causing that inpatient stay.* This extension of Coverage will end on the earlier of the date that:

- 13.10.1** the inpatient stay is no longer Medically Necessary;
- 13.10.2** the Member exhausts the Covered Services available for that inpatient stay and/or medical condition;
- 13.10.3** the Member becomes eligible for Coverage from another group health benefits policy; or
- 13.10.4** twelve (12) months after the termination date of the Agreement.

13.11 Extension of Coverage Upon Total Disability

The Health Plan will continue to provide Covered Services for You if You are Totally Disabled as of the date of the termination of the Agreement. This extension of Coverage will only include Covered Services that are Medically Necessary to treat medical conditions causing or directly related to the Total Disability; and remain in effect until the earlier of the following:

- 13.11.1** You cease to be Totally Disabled; or
- 13.11.2** You have exhausted the Covered Services available for treatment of that condition; or
- 13.11.3** You become eligible for Coverage from another group health benefit policy which does not exclude Coverage for the disabling condition; or
- 13.11.4** Twelve (12) months from the termination date of the Benefit Agreement.

SECTION 14: COMPLAINTS AND GRIEVANCES

We maintain both informal and formal procedures to resolve Member Inquiries, Complaints, and Appeals. These processes give Members the opportunity to ask Us to review any matter related to Covered Services, including but not limited to:

- Issues about the scope of Coverage for health care services;
- Denial, cancellation, or Non-Renewal of

- Coverage;
- Denial of care/services/claims;
- Member rights; and
- The quality of the health care service received.

14.1 Procedure for Filing an Inquiry, Complaint, or Appeal

If a Member has a question regarding any aspect concerning Covered Services, he/she may contact a Customer Service Representative telephonically or in writing, expressing the details of the question to file an Inquiry.

If a Member is dissatisfied with any aspect concerning medical Covered Services, he/she may register a Complaint or Inquiry by contacting a Customer Service Representative telephonically at the number listed on the ID card, or in writing, expressing the details of the Member’s dissatisfaction to file a Complaint.

If a Member is dissatisfied with any aspect concerning any Mental Disorder, Substance Abuse, or Biologically Based Mental Illness related Covered Services, he/she may register a Complaint or Inquiry by contacting a Customer Service Representative telephonically at 1-866-860-7476, or in writing, expressing the details of the Member’s dissatisfaction to file a Complaint.

If the Member does not receive satisfactory resolution to a Complaint/Inquiry regarding an Adverse Benefit Determination of a health service request or benefit that the Member believes he/she is entitled to receive, the Member may file an Appeal/Grievance with Us at the following address or phone number:

Coventry Health Care of Iowa, Inc.
 Attention: Appeals Department
 15950 West Dodge Road
 Omaha, NE 68118
 phone: (800) 471-0240

The Member may file an Appeal/Grievance with Us for any Mental Disorder, Substance Abuse, or Biologically Based Mental Illness related Covered Services at the following address or phone number:

MHNet Behavioral Health
 Attention: Appeals Department

PO Box 209010
 Austin, TX 78720-9010
 866-860-7476

The request for Appeal/Grievance must include:

- Member name and number;
- Provider name;
- Dates of service under Appeal;
- Member’s or Member’s Authorized Representative’s mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why We should “reverse” the Adverse Benefit Determination;
- Copy of documentation to support the reversal of Decision;
- Clear indication of the reason for dissatisfaction.

The written request for an Appeal/Grievance must be filed within one hundred eighty (180) calendar days after a notice of denial (e.g., EOB for denied claims) has been received by the Member. Requests for Appeals/Grievances received after the 180 calendar day period will not be eligible for review under the Health Plan’s Appeal/Grievance process.

If an Authorized Representative wishes to complete an appeal on Your behalf, an Authorized Representative form must be completed and returned to Us. If no Authorized Representative form is completed or verbal authorization granted, then an Appeal cannot be completed and any Appeal requests will be closed. If an Authorized Representative form or verbal authorization, is received after an Appeal request is closed, but within 180 days after notice of denial, a new Appeal will be initiated.

Upon each level of Appeal, the appropriate Health Plan staff, none of whom were involved in any of the prior Adverse Benefit Determinations or levels of Your Appeal will review the Appeal. If the initial determination was made in whole or in part based on a determination of Medical Necessity, or that a service or treatment was Experimental or Investigational, the Appeal will include an evaluation by an appropriate clinical peer of the same or similar specialty as typically manages the condition, procedure or treatment being reviewed.

14.2 Pre-Service Appeal Process

All Pre-Service Appeals will allow You or Your Authorized Representative to present Your position to the Appeal Committee. We will notify You of our decision within thirty (30) calendar days after we receive Your appeal request. A thirty (30) calendar day extension may be granted if the Member or the Member's Authorized Representative request such an extension. A thirty (30) calendar day extension may also be requested by the Health Plan within twenty (20) days of the receipt of the Appeal/Grievance if the Health Plan has not received adequate information to resolve the Appeal. The thirty day extension will be deemed approved if the Member does not object after receiving notice of the Health Plan's request.

14.3 Post-Service Appeal Process

14.3.1 First Level Appeal - A Member's written request of Appeal will be presented for review to the First Level Appeals Committee. We must resolve the Appeal and send written notification of Our decision within thirty (30) calendar days. However, a thirty (30) calendar day extension may be granted if the Member or the Member's Authorized Representative request such an extension. A thirty (30) calendar day extension may also be requested by the Health Plan within twenty (20) days of the receipt of the Appeal/Grievance if the Health Plan has not received adequate information to resolve the Appeal. The thirty day extension will be deemed approved if the Member does not object after receiving notice of the Health Plan's request.

14.3.2 Second Level Appeal - Members who are dissatisfied with the First Level Appeal determination, may appeal to the Second Level Appeals Committee. Written requests for a Second Level Appeal must be received within thirty-one (31) calendar days of receipt of notice of First Level Appeal determination.

The Second Level Appeal review process gives You the right to:

- a) appear before an Appeal committee or communicate with the committee via conference call or other available technology;
- b) present Your case to the Appeal committee;
- c) submit supporting material both before and during the committee meeting;
- d) ask questions of any Appeal committee members;
- e) be assisted or represented by a person of Your choice; and
- f) upon Your request, be provided with all relevant information that is not confidential or privileged.

We must resolve the Appeal and send written notification of Our decision within thirty (30) calendar days. However, a thirty (30) calendar day extension may be granted if the Member or the Member's Authorized Representative request such an extension. A thirty (30) calendar day extension may also be requested by the Health Plan within twenty (20) days of the receipt of the Appeal/Grievance if the Health Plan has not received adequate information to resolve the Appeal. The thirty day extension will be deemed approved if the Member does not object after receiving notice of the Health Plan's request.

If the Member is not satisfied with the decision of Our Second Level Appeal Committee, he or she may pursue normal remedies of the law not later than three (3) years after the date of notice of final determination is given.

14.4 Urgent Care/ Expedited Appeals

In situations involving Urgent Care Appeals, We shall provide verbal notification to the Member or Member's Authorized Representative of Our determination as soon as possible, taking into account the medical exigencies, but not later than thirty-six (36) hours. The Expedited Appeal will be reviewed by a clinical peer(s). Written confirmation of Our decision will be sent within thirty-six (36) hours of

verbal notification of Our decision, so that the entire process is completed in 72 hours. If the Expedited Appeal is a concurrent review determination, the health care service shall be continued without liability to the Member until the Member has been notified of the determination. If the decision is an Adverse Benefit Determination, You may appeal immediately to Our Second Level Appeal Committee. Again, within thirty-six (36) hours an Expedited hearing will be held and You will be notified by telephone of the Committee's decision. Written confirmation of the Committee's decision will follow within thirty-six (36) hours of the verbal notification.

14.5 External Review

Should the decision of our final Appeal Committee be based on a determination of medical necessity, You have the right to file a written request for external review of our Coverage decision with the Iowa Department of Insurance by contacting the Iowa Department of Insurance at 330 Maple Street, Des Moines, Iowa 50319 (515-281-5705).

This request must be filed within sixty (60) calendar days of Your receipt of our Coverage decision and must be accompanied by a twenty-five dollar (\$25) filing fee and a copy of our notice of the Committee's decision. The Iowa Insurance Commissioner may waive the filing fee for a good cause. The filing fee shall be refunded to You if You prevail in the external review process.

You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.

If Your Health Plan is subject to ERISA, You have the right to bring a civil action under ERISA Section 502(a) after You have exhausted the appeal rights provided by the Health Plan by completing a First and Second Appeal.

14.6 Department of Insurance Review

In case of a dispute about any part of this Agreement or if You encounter situations where the performance of the Health Plan does not meet Your expectations, Members who reside in Iowa may contact the

Department of Insurance at:

Iowa Insurance Division
330 Maple Street
Des Moines, Iowa 50319
(515-281-5705)

SECTION 15: CONFIDENTIALITY OF YOUR MEDICAL RECORDS

As part of this Agreement, You agree to provide Us access to any records and medical information held by any provider of Covered Services. You also give Us, Our representatives, and authorized regulators or accrediting bodies access to Your general medical records for:

- claims processing, including claims decisions We make on Your behalf for reimbursement;
- quality assessment and improvement;
- underwriting (for reinstating or adding a Dependent); and
- evaluation of potential or actual claims against Us.

To best serve You, We need information about You. This information may come from You, the Group, or other health benefits plan sponsors. Examples include Your name, address, date of birth, marital status, employment information, or medical history. We also receive information from Providers about the health care services You receive. This information may be in the form of health care claims and encounters, medical information, or a service request.

We maintain policies regarding confidentiality, protection and disclosure of Your nonpublic personal information, including policies related to access to medical records. We may collect, use or share nonpublic personal information to perform Our health care operations, arrange for Your treatment, to pay Your claims or for other purposes permitted or required by law. Nonpublic personal information will not be released to third parties including Your employer, researchers or the government without Your or Your Authorized Representative's consent, except as may be permitted or required by law.

If You have any questions about Our policies or procedures to maintain the confidentiality of

nonpublic personal information please contact Our Customer Service Department.

SECTION 16: RIGHT OF RECOVERY
(THIRD PARTY LIABILITY
SUBROGATION)

If You have a legal right to receive payment from an individual or organization because another party was responsible for Your illness, injury or other loss, We have a right of subrogation, subject to any restrictions imposed by applicable state law, to any funds recovered as a result of this right. In other words, if You accept coverage for Covered Services under this Agreement, You must agree to reimburse Us in full for any benefits paid from any settlement, judgment or other payment You or Your attorney may receive as a result of Your personal injury. It does not matter how these payments are characterized, why they are paid, or whether they are labeled as being compensation for Your medical bills or lost wages.

You are obligated to cooperate with Us to protect Our subrogation rights. This cooperation includes: providing Us with relevant information, signing and delivering documents We reasonably request, and obtaining Our consent before releasing any party from liability. If You enter into litigation or settlement negotiations regarding the obligations of other parties, You must not prejudice, in any way, Our rights under subrogation proceedings. You or Your attorney must inform Us of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. The costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of Your legal representation shall be borne solely by You.

SECTION 17: GENERAL PROVISIONS

17.1 Applicability

The provisions of this Agreement shall apply equally to the Subscriber and Covered Dependents and all benefits and privileges made available the Subscriber shall be available to Covered Dependents.

17.2 Choice of Law

This Agreement shall be administered under the laws of the State of Iowa.

17.3 Clerical Error

Clerical error relating to the Coverage under this Agreement will not invalidate Coverage otherwise validly in force nor continue Coverage otherwise validly terminated.

17.4 Conflicts with Existing Laws

If any provision of this Agreement conflicts with state or federal law, that law shall pre-empt only that provision of this Agreement that is in conflict. If any provision of this Agreement conflicts with the requirements of federal or state law, this Agreement shall be administered in such a way as to comply with the requirements of the law, and will be deemed amended to conform with the law. This Agreement will be amended as required.

17.5 Entire Agreement

The written Agreement shall constitute the entire agreement between the parties. No change to the Agreement shall be valid until approved by an Officer of the Health Plan and such approval is endorsed hereon or attached hereto. No agent has authority to change this Agreement or waive any of its provisions.

17.6 Time Limit on Certain Defenses

All statements, in the absence of fraud, pertaining to coverage under this Agreement that are made by You shall be deemed representations, but not warranties. After two years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by You shall be used in any context to void the coverage, or to reduce or deny benefits.

17.7 Exhaustion of Administrative Remedies

Neither You nor a Group may bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth

in this Agreement have first been exhausted.

17.8 Nontransferable

No person other than You or Your Dependents is entitled to receive health care service coverage or other benefits to be furnished by Us under this Agreement. Such right to health care service coverage or other benefits is not transferable.

17.9 Relationship Among Parties Affected by Agreement

The relationship between the Health Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Health Plan, nor is the Health Plan or any employee of the Health Plan an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Group nor You is an agent or representative of the Health Plan, and neither shall be liable for any acts or omissions of the Health Plan for the performance of services under this Agreement.

17.10 Reservations and Alternatives

We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

17.11 Severability

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

17.12 Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Health Plan, and evidenced by endorsement on this Evidence of Coverage and/or by amendment to this Agreement.

Such amendment will be incorporated into this Evidence of Coverage when applicable.

17.13 Waiver

The failure of the Health Plan, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

17.14 Value Added Services

From time to time We may offer to provide Members access to discounts on health care related goods or services. While We have arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Members for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, We are not liable to the Members for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

17.15 Discounts and Rebates

Member understands and agrees that Health Plan may receive a retrospective discount or rebate from a Participating Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Member shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective premium calculations.

17.16. Overpayments

In the event We pay a sum in error, including but not limited to, payment of claims submitted for dates of service following termination of Your Coverage, upon Our request You must promptly reimburse Us in the amount of any excess benefit You have

received upon Our request. If such payments are not refunded within 30 days of Our written request for such refund, We may commence appropriate action to collect these funds. Provided, We shall not pursue refunds after expiration of the 24 month period commencing the first day of the month following the month in which we discover the error.

17.17 Discretionary Authority

We have the sole discretionary authority to interpret the Subscriber’s plan in order to make eligibility and benefit determinations. We also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement.

17.18 Policies and Procedures

We may adopt policies, procedures, rules and interpretations to promote orderly and efficient

administration of this Evidence of Coverage.

SECTION 18: SERVICE AREA
DESCRIPTION

The Service Area is comprised of the following counties:

In Iowa: Adair; Appanoose; Benton; Black Hawk; Boone; Bremer; Buchanan; Buena Vista; Butler; Calhoun; Carroll; Cedar; Cerro Gordo; Cherokee; Chickasaw; Clark; Dallas; Davis; Decatur; Dickinson; Emmet; Fayette; Floyd; Franklin; Greene; Grundy; Guthrie; Hamilton; Hancock; Hardin; Howard; Ida; Iowa; Jasper; Johnson; Jones; Keokuk; Kossuth; Linn; Lucas; Lyon; Madison; Mahaska; Marion; Marshall; Mitchell; Monroe; Muscatine; O’Brien; Palo Alto; Plymouth; Pocahontas; Polk; Poweshiek; Sac; Scott; Sioux; Story; Tama; Union; Warren; Washington; Wayne; Webster; Winnebago; Winneshiek; Woodbury; Worth; Wright.

Important Addresses and Phone Numbers

To Submit a medical claim, general correspondence, questions regarding claims processing, or to file a written complaint: P.O. Box 7705, London, KY 40742-7705.

To contact Customer Service to verify eligibility and /or benefits, to check status of a medical claim, or to file a verbal complaint:

800-257-4692

For Prior-Authorization:

800-471-0240 ext. 6352

For Urgent Care Out-of-Network, call the number on the back of Your member ID card.

To submit a Mental Disorder, Substance Abuse, or Biologically Based Mental Illness related claim, general correspondence, questions regarding claims processing:

MHNet Behavioral Health
PO Box 209010
Austin, TX 78720-9010

To file a Grievance regarding a Mental Disorder, Substance Abuse or Biologically Based Mental Illness claim:

MHNet Behavioral Health
Attention: Appeals Department
PO Box 209010
Austin, TX 78720-9010

To contact Customer Service to verify mental health benefits, to check status of a Mental Disorder, Substance Abuse or Biologically Based Mental Illness claim, or to file a verbal complaint:

MHNet Behavioral Health: 800-752-7242

To file a pharmacy claim:

Medco Health Solutions, Inc.
Attn: Claims Department
P.O. Box 14711
Lexington, KY 40512

To file a Grievance regarding a medical claim:

Coventry Health Care of Iowa, Inc.
P.O Box 541210
Omaha, NE 68154-9210
800-471-0240

Please visit Us at www.chciowa.com.

A copy of the American Academy of Pediatrics' recommendations for childhood immunizations may be obtained through:

American Academy of Pediatrics
141 Northwest Point Boulevard, P.O. Box 927
Elk Grove Village, Illinois 60009-0927.



PATIENT PROTECTION AND AFFORDABLE COVERAGE ACT/HEALTH CARE AND EDUCATION RECONCILIATION ACT AMENDMENT

Purpose of Amendment:

This Amendment is an attachment to Your Agreement. The information explained in this Amendment modifies the terms of the Agreement under which You are enrolled to receive benefits in compliance with the federal Patient Protection and Affordable Coverage Act of 2010 and the federal Health Care and Education Reconciliation Act of 2010. Please keep this Amendment with the Evidence of Coverage as it becomes part of Your Agreement.

Coverage under this Amendment becomes effective upon the later of September 23, 2010, or the date You become Covered under the Agreement. Coverage under this Amendment ends when Your coverage under this Agreement terminates.

Capitalized terms used in this Amendment and not defined herein shall have the meaning set forth in the Evidence of Coverage.

Nothing in this Amendment shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Evidence of Coverage, other than as specifically stated below. In the event of a conflict between the terms and conditions of this Amendment and the Evidence of Coverage or Schedule of Benefits, the terms and conditions of this Amendment shall control.

Amendments to the Agreement:

I. The "Section 5 - Dependent Eligibility" of the Evidence of Coverage is hereby deleted in its entirety and replaced with the following Section 5 - Dependent Eligibility:

SECTION 5: DEPENDENT ELIGIBILITY

5.1 General Dependent Eligibility Requirements

To be eligible for Coverage as a Dependent, an individual must meet the following requirements:

- 5.1.1** live in the Health Plan Service Area at least nine (9) months out of the year, unless Covered under a Qualified Medical Child Support Order;
- 5.1.2** satisfy any waiting period provided by the Group Master Contract;
- 5.1.3** complete and submit to the Health Plan such applications or forms that the Health Plan may reasonably request; and
- 5.1.4** meet any eligibility criteria specified in the Group Master Contract.

5.2 Eligible Dependents

In addition to meeting the General Dependent Eligibility requirements listed above, to be Covered as a Dependent, an individual must also be one of the following:

5.2.1 the lawful Spouse of the Subscriber;

5.2.2 a child under the Limiting Age of twenty-six (26), or older if provided by the Group Master Contract:

- a) who is either the birth child of the Subscriber or the Subscriber's Spouse;
- b) who is legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
- c) for whom the Subscriber or the Subscriber's Spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order; or
- d) for whom the Subscriber or the Subscriber's Spouse is the court appointed legal guardian;

5.2.3 an unmarried child age twenty six or older, if:

- a) the child has a disability and as a result, they are physically or mentally incapable of earning a living and chiefly dependent on the Member for support and maintenance;
- b) the onset of such incapacity occurred before the Limiting Age; and
- c) proof of such incapacity is furnished to Us by the Member upon enrollment or at the onset of the Dependent child's incapacity prior to reaching the Limiting Age and annually thereafter;

5.2.4 an unmarried child age twenty-six or older if:

- a) the child is both a Full-Time Student and maintains Full-Time Student status after reaching the Limiting Age;
- b) the child had Creditable Coverage during any periods where the child was not Covered by Us; and
- c) the child submits documentation of Full-Time Student status to the Health Plan upon request and at least twice annually.

NOTE: After an unmarried child reaches the Limiting Age of twenty-six (26), if the child ceases to be a Full-Time Student at any time, that child is no longer eligible even if that child becomes a Full-Time Student again at a later date.

“Creditable Coverage” means:

- a) a group health plan;
- b) Health insurance coverage (includes individual coverage);
- c) Part A or Part B Medicare;
- d) Medicaid;
- e) 10 U.S.C. ch. 55;
- f) a health or medical care program provided through the Indian health service or a tribal organization;
- g) a state health benefits risk pool;
- h) a health plan offered under 5 U.S.C. ch. 89;
- i) a public health plan as defined under federal regulations;
- j) a health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e);
- k) an organized delivery system licensed by the director of public health;
- l) a short-term limited duration policy; or
- m) Hawk-I program authorized by chapter 514I.

5.3 Individuals not Eligible for Dependent Coverage

The following are not eligible for Coverage as a Dependent:

5.3.1 A Spouse or child, while on active duty in the armed forces of any country;

5.3.3 A Dependent child's legal dependent;

5.3.4 A child for whom you have only temporary custody or no legal obligation to support; or

5.3.5 A child already receiving Coverage as the Dependent of another Subscriber.

II. The definition of "Preventive" or "Preventive Services" is hereby deleted and replaced with the following:

1.57 "Preventive" or "Preventive Services"

Preventive Services are services that focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for specific problems, and interventions to avert a health problem in non-symptomatic individuals, including:

- (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 (with respect to breast cancer screening, mammography, and prevention, the USPSTF recommendations from November 2009 shall not be included/considered);
- (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 the individual involved; and
- (3) with respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Please refer to the Covered Services Section and Schedule of Benefits for a list of Preventive Services Covered under this Agreement.

III. All terms and conditions related to annual and/or lifetime dollar limits for Covered Services as set forth in the Evidence of Coverage (or any Amendment, attachment, Rider, or Schedule of Benefits) shall be administered pursuant to and in accordance with Section 2711(a) and (b) of the federal Public Health Service Act.

COVENTRY HEALTH CARE OF IOWA, INC.



CHIEF EXECUTIVE OFFICER



DEFINITION OF SPOUSE AMENDMENT

Purpose of Amendment:

This document is an attachment to Your Evidence of Coverage. The information explained in this Amendment modifies the terms of the Agreement under which You are enrolled to receive benefits. Please keep this Amendment with the Evidence of Coverage as it becomes part of Your Agreement.

Coverage under this Amendment ends when Your coverage under this Agreement terminates.

Capitalized terms used in this Amendment and not defined herein shall have the meaning set forth in the Evidence of Coverage.

Nothing in this Amendment shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Evidence of Coverage, other than as specifically stated below. In the event of a conflict between the terms and conditions of this Amendment and the Evidence of Coverage, the terms and conditions of this Amendment shall control.

Amendment:

The definition of "Spouse" included in Your Evidence of Coverage is amended to comply with applicable state law. The term "Spouse" as used in this Agreement means:

A person to whom the Subscriber is validly married:

1.) under the law of the state in which the marriage was entered into; and 2.)

recognized in the state where the Group is located.

A common law spouse qualifies as a Spouse under this Agreement only if his/her spousal status is affirmed by a court of competent jurisdiction.

However, when a benefit is governed solely by federal law that prohibits recognition of same sex marriage, same-sex spouses may not be Covered as a Spouse. Examples of benefits where Spouses cannot be of the same-sex as the Subscriber include, but are not limited to, COBRA continuation coverage and flexible spending accounts (FSAs), health reimbursement accounts (HRAs) or health savings accounts (HSAs).

COVENTRY HEALTH CARE OF IOWA, INC.

A handwritten signature in black ink that reads "Charles R. Stark".

CHIEF EXECUTIVE OFFICER



PROSTHETIC DEVICES AMENDMENT

Purpose of Amendment:

This document is an attachment to Your Schedule of Benefits. The information explained in this Amendment modifies the terms of the Agreement under which You are enrolled to receive benefits. Please keep this Amendment with the Evidence of Coverage as it becomes part of Your Agreement.

Coverage under this Amendment becomes effective upon the later of July 1, 2009, or the date You become Covered under the Agreement. Coverage under this Amendment ends when Your coverage under this Agreement terminates.

Capitalized terms used in this Amendment and not defined herein shall have the meaning set forth in the Evidence of Coverage.

Nothing in this Amendment shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Evidence of Coverage, other than as specifically stated below. In the event of a conflict between the terms and conditions of this Amendment and the Evidence of Coverage or Schedule of Benefits, the terms and conditions of this Amendment shall control.

Amendment:

Any Maximum Benefit, Calendar Year, or Contract Year limit on the dollar amount of Coverage for Medically Necessary Prosthetic Devices for an arm or leg, in whole or in part, is hereby removed.

COVENTRY HEALTH CARE OF IOWA, INC.

A handwritten signature in black ink that reads 'Charles R. Stark'.

CHIEF EXECUTIVE OFFICER



VALID WAIVER ENROLLMENT AMENDMENT

This Amendment only applies to large group plans with 51 or more Subscribers.

Purpose of Amendment:

This document is an attachment to Your Evidence of Coverage. The information explained in this Amendment modifies the terms of the Agreement under which You are enrolled to receive benefits. Please keep this Amendment with the Evidence of Coverage as it becomes part of Your Agreement.

Coverage under this Amendment ends when Your coverage under this Agreement terminates.

Capitalized terms used in this Amendment and not defined herein shall have the meaning set forth in the Evidence of Coverage.

Nothing in this Amendment shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Evidence of Coverage, other than as specifically stated below. In the event of a conflict between the terms and conditions of this Amendment and the Evidence of Coverage, the terms and conditions of this Amendment shall control.

Amendment:

The "Enrollment" section of Your Evidence of Coverage is hereby amended to include the following new provision at the end of the current "Valid Waiver" subsection:

If an eligible Employee and/or his or her eligible dependents waived Coverage under this Health Plan at any time when coverage under the Health Plan was previously offered to them, they may enroll within sixty (60) days of the occurrence of the following:

- a) termination of the employee or dependent's health insurance through Medicaid or CHIP as a result of a loss of eligibility; or
- b) the employee or dependent has become eligible for a premium assistance subsidy under Medicaid or CHIP.

Coverage under the Health Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for enrollment is received unless otherwise provided by the Group Master Contract.

COVENTRY HEALTH CARE OF IOWA, INC.

A handwritten signature in black ink that reads 'Charles R. Stark'.

CHIEF EXECUTIVE OFFICER



**HMO Open Access
Schedule of Benefits**
Citigroup

Benefits

Member Responsibility
In-Network

“Benefit Year” means a calendar year, which is the period of twelve (12) consecutive months commencing on January 1st and continuing through December 31st of that year.

Deductible (Per Benefit Year)	
• Individual Deductible	\$500
• Family Deductible	\$1,000
Coinsurance	10%
Out-of-Pocket Maximum (Per Benefit Year)	
The Out-of-Pocket Maximum includes Deductible and Coinsurance.	
• Individual	\$3,000
• Family	\$6,000
Maximum Lifetime Benefit (while covered under the Health Plan)	Unlimited

Covered Services

Member Responsibility
In-Network

Preventive Services

For services billed as routine including physicals, laboratory, well-baby care, well-child care, well-woman care, mammograms, prostate cancer screening, colon cancer screening, diabetes screening, certain osteoporosis screenings, behavioral health screening, flu shots, and adult and childhood immunizations

\$0 Copayment

Physician Office Services

Primary Care Physician (PCP) Office Visit*

For non-Preventive Services billed by a Physician's office including:

- Non-routine laboratory and radiology services
- Allergy Injections
- Allergy Testing
- Convenient Care Clinic
- Surgery performed in Physician's office

Deductible then Coinsurance

Specialist Physician Office Visit

For non-Preventive Services billed by a Physician's office including:

- Non-routine laboratory and radiology services
- Allergy Injections
- Allergy Testing
- Surgery performed in Physician's office

Deductible then Coinsurance

Covered Services	Member Responsibility
	In-Network
Maternity Services	
Includes prenatal, delivery and postnatal physician services and office visits. For Hospital charges related to delivery or other inpatient Hospital care, refer to Member Responsibility for "Inpatient Hospital." Member Responsibility for 1 st visit only	Deductible then Coinsurance
Urgent Care Facility	
	Deductible then Coinsurance
Outpatient Facility	
For non-Preventive Services including: <ul style="list-style-type: none"> • Services performed at a Hospital or Free-Standing Facility • Non-routine laboratory, radiology and diagnostic testing services 	Deductible then Coinsurance
Emergency Services	
Hospital Emergency Room (Copayment waived if admitted to the hospital)	\$100 Copayment
Ambulance	Deductible then Coinsurance
Inpatient Hospital Services	
<ul style="list-style-type: none"> • Inpatient hospital care, including semi-private room & board, intensive / coronary care, maternity care, x-ray, laboratory and other facility and ancillary charges 	Deductible then Coinsurance
Short Term Therapies	
Speech Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Occupational Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Physical Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Cardiac/Pulmonary Rehabilitation Coverage for up to 36 visits per Benefit Year for all Cardiac and Pulmonary Rehabilitation combined.	Deductible then Coinsurance
Manipulative Therapies	
Spinal Manipulation Coverage for up to 18 visits per Benefit Year.	Deductible then Coinsurance
Other Manipulative Therapies	Deductible then Coinsurance
Other Services	
Family Planning <ul style="list-style-type: none"> • Elective Sterilization, Male or Female • Infertility Diagnosis only • Infertility Treatment 	Deductible then Coinsurance Deductible then Coinsurance No Coverage
Nursing Facility/Nursing Care Coverage up to 60 days per Benefit Year	Deductible then Coinsurance
Home Health Care Coverage up to 60 visits per Benefit Year	Deductible then Coinsurance
Hospice Care <ul style="list-style-type: none"> • Inpatient • Outpatient 	Deductible then Coinsurance Deductible then Coinsurance

Covered Services	Member Responsibility
	In-Network
<u>Durable Medical Equipment (DME)</u>	Deductible then Coinsurance
<u>Oxygen</u>	Deductible then Coinsurance
<u>Prosthetic Devices</u> <ul style="list-style-type: none"> • Arm or Leg, in whole or in part • Other Prosthetic Devices 	Deductible waived, then Coinsurance Deductible then Coinsurance
<u>Transplant Services</u> Must be performed at a Coventry Transplant Network Facility approved by Us	Copayments, Deductible and Coinsurance apply as specified in this Schedule of Benefits, based on place and type of services rendered.
<u>Outpatient Prescription Drugs</u>	Covered if Outpatient Prescription Drug Rider is attached to Evidence of Coverage. If applicable, refer to Outpatient Prescription Drug Rider for benefit details.
<u>Mental Disorder, Substance-Related Disorder, and/or Biologically Based Mental Illness Coverage</u> (with the exception of certain screenings)	Covered if Rider is attached to Evidence of Coverage. If applicable, refer to the Rider for Mental Disorder, Substance-Related Disorder and/or Biologically Based Mental Illness for benefit details.

* Primary Care Physicians (“PCP”) generally include those Physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, OB/GYN or Pediatrics. If You are not sure if a Physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive a service from a PCP, your PCP Member Responsibility will apply. If you receive this service from a Specialist, your Specialist benefit will apply.

Only services and treatments that meet both Our Medical Necessity criteria and are listed as a Covered Service in the Agreement will be Covered. Services and treatments listed under the Exclusions and Limitations Section are not Covered, regardless of Medical Necessity. Even though your Provider may recommend a procedure, service, or supply, the care may not always be Medically Necessary. See your Evidence of Coverage (EOC) for further details on Medical Necessity, Covered Services and a listing of Exclusions and Limitations.

Some Covered Services that You receive during a Preventive Services visit may not qualify as Preventive Services under the Agreement and, consequently, will be subject to applicable Copayment, Coinsurance and/or Deductible.

It is Your obligation to ensure that any required Prior Authorization has been obtained. Before you receive certain services, supplies, or procedures, You or Your Participating Physician must request any necessary Prior Authorization. If You choose to have requested services performed even though We were unable to certify the Medical Necessity of the services, You will be responsible for the charges.

If you are unsure if a service requires Prior Authorization, contact Us at the Customer Service phone number listed on the back of your ID card prior to receiving care.

This Schedule is part of Your Evidence of Coverage (EOC) but does not replace it. Many words are defined elsewhere in the EOC and other limitations or exclusions may be listed in other sections of your EOC. Reading this Schedule by itself could give you an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your EOC. A complete list of Covered Services, Exclusions, and Limitations can be found in Your EOC.