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

Welcome to Coventry Health Care!

We are extremely pleased to have you enrolled 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 member, it is important that you understand the way your health plan operates. This Evidence of Coverage (EOC) 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.

Customer Service Department

(800) 257-4692

Monday through Friday

8:00 a.m. to 5:00 p.m. Central Time

We look forward to serving you and your family.

Coventry Health Care of Iowa, Inc. (CHC)

Evidence of Coverage

The Agreement between CHC (hereafter called the "Health Plan", "CHC", "We", "Us", or "Our") and You and between the Health Plan and Your Dependents as Members of the Health Plan is made up of:

- This Evidence of Coverage, amendments and addendums ("Certificate");
- The Enrollment Form;
- The Schedule of Benefits;
- Applicable Riders; 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 the 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.

The Health Plan coordinates Covered Services and provides related administrative duties. When You use Our Participating Providers, You receive Your full benefits for Covered Services, minus applicable Copayments and Coinsurance. For services to be Covered, they must be Medically Necessary, provided by a Participating Provider (except in the case of Transplant Services where services must be provided by a Coventry Transplant Network Facility. See Section 5 of this Certificate.) and in certain instances Prior Authorized by Us. **THERE IS NO OUT OF NETWORK OPTION UNDER THIS AGREEMENT; ALL SERVICES INCURRED OUT OF NETWORK WILL BE THE MEMBER'S RESPONSIBILITY.**

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement 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 for this Agreement. You should keep this document in a safe place for Your future reference.

Coventry Health Care of Iowa, Inc.
4600 Westown Parkway, Suite 200
West Des Moines, Iowa 50266-1099
(800) 470-6352 or (515) 225-1234

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of Coventry Health Care of Iowa, You have the right to:

- Receive information about the Health Plan, its services, practitioners and Your rights and responsibilities.
- Be treated in a manner reflecting respect for Your privacy and dignity as a person.
- Not be discriminated against because of age, disability, race, color, religion, sex, or national origin.
- Be informed regarding diagnosis, treatment and prognosis in terms that You can be expected to understand.
- Participate in the decision-making process regarding Your medical care. Your health care professional should advise You of treatment alternatives so that You and he/she may select the appropriate treatment plan.
- Receive sufficient information to enable You to give informed consent before the initiation of any procedure and/or treatment.
- Refuse treatment to the extent permitted by law and to be made aware of the potential medical consequences of such actions.
- Expect that all communications and records pertaining to Your health care will be treated as confidential, and that no such records will be released without Your authorization. Your signature on the enrollment form constitutes permission for release of medical records to the health plan for You or Your family Dependents as listed on the enrollment form.
- Select Your own personal physician from among health plan participating physicians, as appropriate, and to expect that physician to provide quality care, and to arrange for and coordinate all care You receive.
- Reasonable access to necessary medical services.
- Express a complaint regarding the health plan or the care provided to You, and to expect an answer within a reasonable period.
- Call the health plan whenever You have a question about our HMO or Your benefits.
- Make recommendations regarding the Plan Members' rights and responsibilities policies.

As a Member of Coventry Health Care of Iowa, You have the responsibility to:

- Read Your Evidence of Coverage and Group Membership Services Contract. You are subject to all of the terms, conditions, limitations and exclusions in the Agreement. You are also subject to all the rules and regulations of the Health Plan as detailed in both the handbook and the Agreement.
- Always seek care through Your Participating Provider, if applicable.

- Obtain a referral and/or Authorization from Your participating physician, as applicable, before receiving services from a specialist, hospital, or other provider. Retroactive referrals are not Covered.
- Always identify Yourself as a Health Plan Member when calling for an appointment and when obtaining health care services.
- Keep scheduled appointments or, if necessary, call to cancel appointments as early as possible. Remember Your Participating Provider may bill You if You fail to keep a scheduled appointment.
- Inform us of any additional health insurance Your family may have so that payments can be properly coordinated between the other insurer and Us.
- Cooperate with Your health care professionals and follow their advice for treatment of injuries or illnesses.
- To give the provider the information necessary to provide health care.
- Know how to recognize an urgent care condition versus a medical emergency and what to do if one should occur.
- Understand Your health problems and participate in developing mutually agreed upon if one should occur.

NOTE: Additional Member rights are honored as dictated by State and Federal mandates.

SECTION 1
USING YOUR BENEFITS

1.1 Membership Identification (ID) Card

Every Health Plan Member receives a membership identification card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive Covered Services. If Your Health Plan ID card is missing, lost, or stolen, visit the CHC Website at www.chciowa.com or contact the Health Plan Customer Service Department at (800) 257-4692 to obtain a replacement.

1.2 Participating Providers

You may check with the Provider Directory, Website, or a Customer Service Representative to see if a Provider is Participating in Our network. We reserve the right to make changes in Our Participating Provider network as appropriate or necessary.

1.3 Utilization Management Program

Our Utilization Management Program is designed to assure that You and Your Dependents receive Medically Necessary health care in a timely manner, 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.

Several services require Pre-Authorization by Us to be Covered. Pre-Authorization means Authorization by Us **prior** to a Member accessing services. These services include but are not limited to:

- Inpatient Hospital Admissions;
- Infertility, if Covered;
- Outpatient Therapy(ies) (Occupational, Physical, and Speech);
- Outpatient Surgeries;
- Organ Transplant Services;
- Oral Surgical Services;
- Reconstructive Surgery;
- Rehabilitative Service (Pulmonary and Cardiac);
- Nursing Facility Care;
- Home Health Care;
- Hospice Care;
- Durable Medical Equipment purchases and rentals;
- Prosthetic Devices; and
- Sleep Studies.

Additional services may be added to the above list from time to time as deemed necessary by Us.

When You or Your Dependents receive care from a Participating Provider, the Participating Provider is responsible for following the Utilization Management policies and procedures.

Not all medical services are Covered. The purpose of Pre-Authorization is to determine whether the requested service or admission meets Medical Necessity criteria and is Covered. If You elect to have the requested service performed even though We were unable to certify the Medical Necessity or the service is not Covered under Your benefit plan, You will be financially responsible for all charges for services incurred and not Authorized. Under all circumstances, the attending Physician and You are ultimately responsible for the medical decisions regarding treatment of You or Your Dependent.

All requests for Pre-Authorization must be made a minimum of two (2) working days prior to the scheduled service or admission and will not be considered complete until all required information is supplied to Us. The information required includes, but not limited to the following:

- Patient demographics (name, address, date of birth, identification number);
- Proposed treatment/procedure/admission/service;
- Provider requesting service;
- Supporting history and physical findings;
- Physician evaluation/treatment;
- Evaluation and proposed treatment plan for therapies and home health care;
- Appropriate diagnosis and ICD-9 codes; and
- Scheduled date of service/admission.

Following review of all the documentation provided, We will inform You, the requesting Physician and the facility, as appropriate, in writing of the Authorization approval or denial.

An elective admission is a hospitalization that is non-emergent and can be scheduled in advance. Your Physician requests Pre-Admission Authorization from Us. You should confirm that the request for Pre-Admission Authorization has been obtained.

Continued stay review will be conducted on all inpatient stays while You are in a Hospital, Nursing Facility or other facility as appropriate. The Health Services staff will initiate this review. If the continued stay is not approved, You, Your Physician, and the facility will be notified in writing of the denial and provided with information on Your appeal rights.

In the event of an emergency hospitalization or outpatient surgery or procedure, We must be contacted on the next business day after the date of service or as soon as reasonably possible following the admission or surgery/procedure.

If We Authorize an admission, outpatient surgery or procedure or other services based on information later determined by Us to be inaccurate and the Authorized services are determined to be not Medically Necessary or a non-Covered Service,

payment will be denied for charges incurred and You will be financially responsible for these charges.

You have the right to appeal any Utilization Management Program payment decisions according to Our Inquiries, Complaints and Grievances procedures. (Refer to Section 10)

1.4 Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to Participating Providers at the time of service. Coinsurance amounts, based on Our reimbursement to the Provider, will be billed to You at a later time by the Provider. Specific Copayments and Coinsurance amounts are listed in the Schedule of Benefits. You are responsible for paying Deductibles incurred in a Calendar Year. Coinsurance and Deductible amounts are not to exceed the Out-of-Pocket Maximum specified in the Schedule of Benefits.

When a Covered Individual incurs Covered charges in the last three (3) months of a Calendar Year which applies to the Covered Individual's Deductible for that year, such amounts are also applied to the Covered Individual's Deductible amount due for the following year, if the prior year Deductible has not been satisfied in full.

1.5 Out-of-Pocket Maximum

The individual Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified Covered Services in a Calendar Year, as specified in Your Schedule of Benefits. 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 Calendar Year. Coinsurance and Deductibles apply to the Out-of-Pocket Maximum. Copayments do not apply to Your Out-of-Pocket Maximum.

1.6 Maximum Lifetime Benefit

The Maximum Lifetime Benefit payable per Member, if applicable, is listed in the Schedule of Benefits. Once a Member reaches their Maximum Lifetime Benefit coverage will be terminated the last day of the month in which the Maximum Lifetime Benefit is met.

1.7 New Technology Assessment

CHC uses a new technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including but not limited to:

- Medical procedures;
- Drugs and drug therapies; and
- Devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical

databases, specialty medical societies, applicable government publications, CHC Medical Directors and pharmacy department and specialists, researchers, or institutions who specialize in the condition involved as needed.

The following factors will be considered when evaluating the proposed technology:

- Does the technology have final approval from the appropriate regulatory bodies?
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome; and must be as beneficial as any established alternatives.

To use a technique before it has been adequately tested and established may pose a risk to a patient's safety or require the use of substantial resources with no reasonable likelihood of benefit from treatment.

This process has been established to make Our determinations for Coverage based on a scientifically and medically sound process that will appropriately identify and distinguish those procedures, drugs and devices that have not yet been proven to be sufficiently safe and effective.

To prevent exposure to unwarranted risk and ensure the effective use of medical resources, Coventry Health Care of Iowa will exclude Coverage for new technology procedures, drugs and devices that are deemed by Us to be Experimental or Investigational.

1.8 How to Contact the Health Plan

Throughout this Agreement, 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 www.chciowa.com or at the Customer Service telephone number on Your identification card.

1.9 Submission of Bills and Claims

After receiving health care services, CHC must receive a claim to process Your benefits accurately. Participating Providers have agreed to file claims for You. You may need to file a claim when You utilize a Non-Participating Provider who does not agree to file a claim with CHC on Your behalf. When a Non-Participating Provider does not agree to file a claim directly with Coventry, You need to provide the following information to:

Coventry Health Care of Iowa, Inc.
P.O. Box 7709
London, KY 40742

Your claim filing responsibilities:

- Member ID Number of patient,
- Member name, address, and relationship to Employee
- Date of service, diagnosis code, CPT-4 procedure code,
- Provider name, address, and tax identification number,
- Invoice or billing statement from the Provider.

Benefits will be paid directly to You It is Your responsibility to make payment to the Non-Participating Provider.

You can find a medical claim form at www.chciowa.com to assist You when filing a claim.

Bills or claims will not be accepted later than one (1) year after the date of service.

SECTION 2
ENROLLMENT AND ELIGIBILITY

2.1 Eligibility

2.1.1 Subscriber Eligibility - To be eligible to be enrolled You must:

- Live or work in the Service Area at least nine (9) months out of the Calendar Year unless on temporary work assignment of six (6) months or less; and
- Be an Employee that is Actively at Work or Retiree of the Group; and
- Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of his/her own status with the Group, and not by virtue of dependency; and
- Meet any eligibility criteria specified by the Group and approved by CHC, including, without limitation, the criteria set forth in Section 2.2 below (Retiree); and
- Complete and submit to CHC such applications or forms that CHC may reasonably request.

2.1.2 Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Live in the CHC Service Area at least nine (9) months out of the year, except as permitted under section e) below; and
- Be the lawful spouse of the Subscriber or be an unmarried child of the Subscriber or the Subscriber's spouse including:

  a) Children under age nineteen (19) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or legally placed for adoption with the Subscriber or Subscriber's spouse;

  b) Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care Coverage pursuant to Qualified Medical Child Support;

  c) Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;

  d) Children nineteen (19) or older who are either the birth or legally adopted children of the Subscriber or the Subscriber's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity is furnished to Us by the Subscriber upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity

prior to age nineteen (19) and annually thereafter;

e) Children under the age of twenty-four (24), or other age as defined in the Group Master Contract, who are either the birth or legally adopted children of the Member and are attending an accredited educational institution defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program on a full-time basis, provided that the Subscriber provides documentation of such attendance to CHC upon request. Coverage ends the last day of the month in which the Dependent attains the age of twenty-four (24) or is no longer enrolled in school on a full-time basis.

Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his/her spousal status is affirmed by the jurisdiction in which he/she lives. A common law marriage is established in Iowa by the parties' intent and agreement to be married, their continuous cohabitation, and their public declarations that they are husband and wife.

2.2 Retirees

A Retiree or Retiree's spouse who is eligible to be covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B Coverage on the later of the date he/she is first eligible for Medicare or the effective date of this Agreement in order to be eligible or continue Coverage under this Agreement. If a Retiree or a Retiree's spouse does not enroll within thirty-one (31) days of the later of the date he/she is first eligible for Medicare or the effective date of this Agreement, his/her Coverage under this Agreement shall terminate.

2.3 Change of Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by CHC.

2.4 Persons Not Eligible to Enroll

2.4.1 A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with CHC for Coverage under this Agreement.

2.4.2 A person whose Coverage under this Agreement was terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with CHC for Coverage under this Agreement.

2.4.3 Late Enrollees are not eligible to enroll except during the next Group Enrollment Period.

2.5 Enrollment

2.5.1 Group Enrollment Period: All eligible Employees or Retirees of a Group and their eligible Dependents may enroll with CHC for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

2.5.2 Any new Employee or Employee who transfers into the CHC Service Area may enroll with CHC for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the Employee fails to submit a CHC Enrollment Application for purposes of enrolling with CHC 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.

2.5.3 A special enrollee may enroll with CHC for Coverage under this Agreement as provided below.

2.6 Special Enrollment

2.6.1 Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an Employee and his or her Dependents may enroll in this Health Plan if the Employee waived initial Coverage under this Health Plan at the time Coverage was first offered because the Employee or Dependent had other Coverage at the time Coverage under this Health Plan was offered and the Employee's or Dependent's other Coverage was:

- COBRA continuation coverage that has since been exhausted; or,
- If not COBRA continuation coverage, such other Coverage terminated due to a loss of eligibility for such Coverage or employer contributions toward the other Coverage terminated. The term "loss of eligibility for such Coverage" includes a loss of Coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. This term does not include loss of Coverage due to failure to timely pay required contributions or premiums or loss of Coverage for cause (i.e., fraud or intentional misrepresentation).

Required Length of Special Enrollment. An Employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other Coverage was lost.

Effective Date of Coverage. If the 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 special enrollment is received.

2.6.2 Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth below, an Employee and his or her Dependents may enroll in this Health Plan if the Employee has acquired a Dependent through marriage, birth, legal adoption or legal placement for adoption.

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

marriage to You, or upon the birth, legal adoption or legal placement for adoption of his or her child (even if the child does not enroll).

- New Dependents of Covered Employee. A child who becomes a Dependent of a Covered Employee as a result of marriage, birth, legal adoption or legal placement for adoption may enroll at that time.
- New Dependents of Non-enrolled Employee. A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, legal adoption or legal 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.

Required Length of Special Enrollment. An Employee and his or her Dependents must request special enrollment, in writing, no later than thirty-one (31) days from the date of marriage, birth, legal adoption or legal placement for adoption.

Effective Date of Coverage. Coverage shall become effective:

- In the case of marriage, the date of such marriage provided an enrollment form is received within thirty-one (31) days from the date of the event; and,
- In the case of a Dependent's birth, the date of such birth as described in Section 3.2.2; and,
- In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Please note: You may add family members to Your Coverage as Late Enrollees only at Your Employer or group sponsor's annual enrollment period. You may add family members to Your Coverage as Special Enrollees at any time, as described in this Section.

2.7 **Notification of Change in Status**A Covered Employee must notify the Health Plan of any changes in Your status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Change of Status form to the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency 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 3
EFFECTIVE DATES

3.1 Effective Date

3.1.1 During Group Enrollment Period: An Employee or Retiree 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, a date mutually agreed to by CHC and the Group.

3.1.2 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 CHC receives the Employee's completed Enrollment Form within thirty-one (31) days of the date that the Employee first became eligible for Coverage.

3.1.3 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 CHC receives the Employee's Enrollment Form within thirty-one (31) days of the date that the Employee first became eligible for Coverage.

3.1.4 Special Enrollees: Special enrollees shall be Covered under this Agreement as provided in Section 2 above.

3.2 Member Effective Date for Dependents

3.2.1 Dependents may be enrolled during a Group Enrollment Period, upon the valid enrollment of a newly hired or newly eligible Employee (as provided in Section 3.1 above). In the case of Dependents who are enrolled during the Group Enrollment Period or upon the valid enrollment of a newly hired or eligible Employee, the Dependent Effective Date shall be the same as the Member Effective Date.

3.2.2 Dependents who are special enrollees can be covered under this Agreement when stated in Section 2.6 above; provided that a child born to a Subscriber will be covered for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first thirty-one (31) days from the date of birth upon receipt of the Enrollment Form. Applicable premiums must be paid for this Coverage. For Coverage to continue beyond the first thirty-one (31) days, an application to add the child as a Dependent must be received within thirty-one (31) days from the date of birth. Any newborn that is covered for the first thirty-one (31) days from the date of birth but is not eligible to enroll as a Dependent under this Agreement may convert to an individual contract under the terms and conditions set forth in Section 9 of this Agreement. Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order shall be Covered 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.

3.3 Inpatient on the Member Effective Date

Regardless of whether a person is confined as an inpatient in a Hospital, Nursing Facility or Hospice on the date such person is to become a Member, the person shall become a Member on such effective date.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Coverage For Members

Your Coverage shall terminate upon the occurrence of any one of the following events:

- At least thirty-one (31) days notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under this Agreement.
- At least thirty-one (31) days notice of termination of a Retiree or the Retiree's spouse if the Retiree or the Retiree's spouse is eligible to enroll in Medicare (Title XVIII of the Social Security Act as amended) and fails to enroll in Medicare Part A and B Coverage within thirty-one (31) days of the later of the date that the Member first becomes eligible to enroll or the Member Effective Date.
- At least thirty-one (31) days notice of the termination of Your Coverage due to the nonpayment of premiums or supplemental charges (Copayments, Coinsurance, Deductible) required for Hospital or medical services.
- Upon the termination or non-renewal of the Group Master Contract, by the Group.
- At least thirty-one (31) days notice of termination to You if You and Your Physician fail to establish a satisfactory patient-physician relationship and:
    - CHC has, in good faith, provided You with the opportunity to select an alternative Physician;
    - You have repeatedly refused to follow the plan of treatment ordered by the Physician;
    - You have been notified by CHC in writing at least thirty-one (31) days in advance that the patient-physician relationship is unsatisfactory and specific changes are necessary in order to avoid termination; and
    - You have failed to make a good faith effort to make the specific changes outlined in CHC's notice detailed in sub-section immediately above.

  If a Dependent fails to establish a satisfactory patient-physician relationship, only the Coverage of the Dependent shall be terminated. If the Subscriber fails to establish a satisfactory patient-physician relationship, the Coverage of the Subscriber and his/her Dependents will be terminated.

- At least fifteen (15) days written notice if You participate in fraudulent

or criminal behavior, including but not limited to:

- Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including 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. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
- 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.
- 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.
- Knowingly misrepresenting or giving false information on any Enrollment Form which is material to CHC's acceptance of such application.

4.2 Effect of Termination

If Your Coverage under this Agreement is terminated under Section 4.1, all rights to receive Covered Services shall cease as of the date of termination.

Identification cards are the property of CHC 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.

Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of your rights under CHC's Complaint and Appeal procedures. CHC may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

4.3 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.

SECTION 5
COVERED SERVICES

The Health Plan Covers only those health services, supplies, drugs, and equipment that are (1) deemed Medically Necessary, (2) provided by a Participating Provider (except in the case of Transplants where services must be provided by a Coventry Transplant Network Facility. See section 5.6 of this Agreement.) and (3) not Excluded under the Exclusions and Limitations set forth in Section 6.

The following section, **Table of Covered Services,** lists the Health Care services, supplies, equipment, and drugs Covered under this Agreement. This section is provided to assist You with determining the level of Coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the Exclusions and Limitations set forth in Section 6. All Prior Authorizations and determinations referenced in Covered Services are made by Us. If a service is Medically Necessary but not specifically listed and not otherwise Excluded, please contact Us to confirm whether the service, supply, drug, or equipment is a Covered Service. This list includes but is not limited to the following services, supplies drugs and equipment and is subject to change at any time.

5.1 Table of Covered Services

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	Prior Authorization is not required.
Ambulance	Covered Service for ground ambulance to Hospital when ambulance travel is determined to be Medically Necessary. Covered Service for air ambulance when determined by Us to be a Medical Emergency.	Prior Authorization required unless emergent in nature, as determined by Us. Emergency out of area air ambulance will be paid at the Out-of-Network Rate, as determined by Us, with the Member responsible for the balance of charges.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Blood and Blood Products	Covered Service for administration, storage, and processing of blood and blood products in connection with services covered under the Evidence of Coverage.	Prior Authorization is not required.
Breast Reconstruction	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: • 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. Coverage will be provided in a manner determined in consultation between You and Your attending Physician.	Prior Authorization required.
Cardiac Rehabilitation Therapy	Covered Service following an acute event, but limited to treatment for therapy conditions that in the judgement of a Participating Physician and the Medical Director are subject to significant improvement of Your condition through Short-Term Therapy.	Prior Authorization required. Limited to sixty (60) consecutive days from the onset of treatment unless otherwise specified in Your Schedule of Benefits.
Chemotherapy and radiation therapy	Covered Service for the treatment of cancer.	Prior Authorization is not required.
Chiropractic Services	See Spinal Manipulation	

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Dental & Oral Surgical Services	Coverage benefit limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums. Covered Service 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.	Limited benefit. Prior Authorization required. Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal treatment, surgery for impacted teeth, surgery involving structures directly supporting the teeth, or orthodontia. Additional exclusions in Section 6.
Dermatological Services	Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.	Prior Authorization is not required when performed in an office setting.
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 will be a Covered Service.	Prior Authorization is not required.
Disposable Supplies	Not Covered, except for ostomy & certain disposable diabetic supplies not covered under a prescription rider. Covered for 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.	Prior Authorization required.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Durable Medical Equipment (DME)	Covered Service when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part, and when **all** of the following circumstances apply: (1) it can withstand repeated use; (2) it is primarily and customarily used to serve a medical purpose; (3) it is generally not useful to a person in the absence of illness or injury; and (4) it is appropriate for use in the home.	Prior Authorization is required. Consult the Schedule of Benefits for any limitations. Glucometers will be obtained from Coventry Health Care's Health Services Department. Replacement and repair of prosthetic devices and DME is based on Medical Necessity and limited to $1,000/year. Rental amount or purchase price amount for any Durable Medical Equipment item and length of any rental term will be determined by Us. Upgrades to equipment are the responsibility of the Member.
Elective Sterilization	Covered Service.	Prior Authorization is not required when performed in an office setting.
Emergency Services	Covered Service as set forth in Section 5.2. The CHC definition of "Emergency Services", "Emergency Medical Condition", and "Emergency Out of Area" are found in the definition section.	Emergency Room visits do not require Prior Authorization from or notification to Us. If admitted to a hospital, You should notify CHC within 48 hours of admission or the next business day or as soon as physically possible.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Eyeglasses and Corrective Lenses	Not a Covered Service, except when necessary for the first pair of corrective lenses following cataract surgery performed while You are enrolled with Us.	Prior Authorization required.
Family Planning	Covered Service includes counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and Norplant and measurement for contraceptive diaphragms.	Prior Authorization is not required.
Genetic Counseling	Covered Service for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities.	Prior Authorization required.
Home Health Care	Covered Service when **all** of the following requirements are met: (1) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; and (2) the services are a substitute or alternative to hospitalization; and (3) part-time intermittent services are required; and (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the Member is at home.	Prior Authorization required.
Hospice	Covered Service when in the judgement of the Participating Provider, the Member's life expectancy is six (6) months or less.	Prior Authorization required.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Immunizations	Covered Service.	Immunizations for routine childhood immunizations and flu shots do not require Prior Authorization by Us. Prior Authorization required for immunizations other than routine childhood immunizations. Immunizations for travel or employment are not Covered
Infertility	Covered Service only for the diagnosis of Infertility.	Prior Authorization required. Treatment of Infertility is not Covered.
Injections: Therapeutic Injections, IV Infusions, and Self-Administered Injectable Drugs	Coverage is provided for therapeutic injections, IV infusions and certain self-administered injectable drugs when FDA-approved, medically appropriate, subject to the Health Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Health Plan.	Prior Authorization required. Self-Administered Injectable Drugs are Covered by a Pharmacy Rider and/or Self-Administered Injectable Drug Rider and therefore are Excluded from the medical benefit. See Exclusions Section regarding Prescription medications and Self-Administered Injectable Drugs.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Inpatient Hospital Care	Covered Service includes, but is not limited to: (1) room and board; (2) general nursing care; (3) use of equipment and supplies; (4) use of operating room/recovery room/treatment room; (5) semi-private room or private room when Medically Necessary; (6) intensive care, coronary care unit and related Hospital services; (7) anesthesia services and supplies; (8) laboratory and radiology examinations; (9) medication used while inpatient; and (10) professional services.	Prior Authorization required unless emergency admission. Unless We have given specific Authorization, You must be admitted to a Participating Hospital and be under the care of a Participating Physician to be eligible for non-emergency Covered Services benefits. Consistent with Our Utilization Management Program, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity 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 that Coverage will cease.
Laboratory Services	Covered Service.	Prior Authorization is required.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Maternity Services	Covered Service for the professional prenatal and postpartum period and during Hospital confinement. Newborn children are covered from the date of birth for a period of thirty-one (31) days upon receipt of the Enrollment Form. For Coverage to continue beyond the first thirty-one (31) days, the Enrollment Form to add the child as a Dependent must be received within thirty-one (31) days from the date of birth.	Authorization required for Hospital length of stay in connection with childbirth for the mother and newborn in excess of forty-eight (48) hours following a normal vaginal delivery and in excess of ninety-six (96) hours following a cesarean section.
Medical Complications	Covered Service for complications arising from Medically Necessary surgery for Covered Services, (regardless of Health Plan membership status at the time of surgery).	Prior Authorization Required. Not a Covered Service if complications occurred when You did not follow the course of treatment prescribed by a Participating Provider. Not a Covered Service if the complications arise from Non-Covered Services. Although the requested service may be Medically Necessary, if the complication is from a non-Covered Service, the requested service is not covered.
Mental Health Services	See Section 5.4.	

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Nursing Facility	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.	Prior Authorization required. Days per Member per Calendar Year may be limited as listed in Your Schedule of Benefits. Custodial care is Excluded.
Nutritional Counseling	Covered Service when provided by a Registered Dietician or Participating Physician.	Prior Authorization required. Limited to three (3) visits per Calendar Year.
Occupational Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function or impairment due to trauma, stroke, a surgical procedure, or other acute condition, and when significant improvement can be achieved through Short-Term Therapy.	Prior Authorization required. Limited to sixty (60) consecutive days from the onset of treatment unless otherwise specified in Your Schedule of Benefits.
Orthotics	See DME Covered Service benefit description.	Prior Authorization required. Foot orthotics are not Covered (e.g., shoe inserts, special shoes)

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Physical Therapy	Covered Service when determined to be Medically Necessary to restore normal physical function or impairment due to trauma, stroke, a surgical procedure, or other acute condition, and when significant improvement can be achieved through Short-Term Therapy.	Prior Authorization required. Limited to sixty (60) consecutive days from the onset of treatment unless otherwise specified in Your Schedule of Benefits.
Podiatry	Covered Service	Prior Authorization is not required when performed in an office setting. Not a Covered Service for routine foot care such as removal or reduction of corns and calluses, clipping of toenails, treatment of flat feet, fallen arches, and chronic foot strain.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Preventive, Diagnostic and Treatment Services	Covered Services include, but are not limited to: (1) Preventive care, including well-baby care and periodic check-ups according to the preventive care guidelines adopted by the Health Plan. (2) Diagnosis and treatment of illness or injury. (3) Consultations with Participating Specialists. (4) Laboratory tests, when obtained at a Participating Provider of laboratory services. (5) Obstetrical care, including prenatal, delivery and postpartum care, and including inpatient care in accordance with the Health Plan medical criteria. (6) PSA test, (one in a twelve (12) month period) and digital rectal examinations. (7) Colon cancer screening (8) Well-woman care: One pap smear in a twelve month period and low-dose screening mammograms for determining the presence of breast cancer in accordance with guidelines of the Health Plan.	Care that is not an Emergency Medical Service must be received from Participating Providers.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
Prosthetic Devices	Covered Service when determined to be Medically Necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part.	Prior Authorization required. One-time limit to one each per Member per lifetime unless You require refitting and a replacement due to structural change in anatomy, in which case the replacement must be Prior Authorized. Coverage for prosthetic devices will be through the DME benefit.
Pulmonary Rehabilitation Therapy	Covered Service, but limited to treatment for conditions that in the judgment of a Participating Physician and the Medical Director are subject to significant improvement of Your condition through Short-Term Therapy.	Prior Authorization required. Limited to sixty (60) consecutive days from the onset of treatment unless otherwise specified in Your Schedule of Benefits.
Radiology	Covered Service.	Prior Authorization required.
Reconstructive Surgery	Covered Service for repair of disfigurement for restoration of function resulting from an illness or injury that occurs while a Member is enrolled in the Health Plan.	Prior Authorization required. Cosmetic surgery is not Covered.
Second Surgical Opinion	Covered Service.	Prior Authorization is not required.
Sleep Studies	Covered Service.	Prior Authorization required.

Coverage for services or supplies when determined by CHC to be Medically Necessary and provided by PARTICIPATING Providers		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATIONS, REQUIREMENTS, LIMITATIONS, and/or EXCLUSIONS**
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 to be achieved through Short-Term Therapy.	Prior Authorization required. Limited to sixty (60) consecutive days from the onset of treatment unless otherwise specified in Your Schedule of Benefits.
Spinal Manipulation	Covered Service for treatment of musculoskeletal injuries or conditions.	Prior Authorization is not required. Limited to twenty (20) visits per Calendar Year unless otherwise specified in Your Schedule of Benefits.
Surgical Services	Covered Service.	Prior Authorization required. For oral surgery services, see Dental and Oral Services.
Termination of Pregnancy	Covered Service for termination of pregnancy during the first and second trimester.	Prior Authorization is not required when performed in an office setting.
Transplants	See Section 5.6.	

5.2 Emergency Benefits

In the event You experience an Emergency Medical Condition, 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.

If admitted to a Hospital, You should contact CHC the next business day or as soon as is reasonably possible under the circumstances. The determination of Covered Services for services rendered in an emergency facility is based on Our review of Your emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services rendered by non-Participating Providers or in non-Participating facilities are not a Covered Service if You remain in a non-Participating facility after We have made the appropriate arrangements for transfer to a Participating facility.

5.2.1 What is an Emergency Medical Condition?

An Emergency Medical Condition is the sudden onset of acute symptoms of sufficient severity (including pain) which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Some examples of an Emergency Medical Condition include but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or Unusual Bleeding;
- Severe Burns;
- Suspected poisoning;
- Trouble breathing; and
- Vaginal bleeding during pregnancy.

5.3 Urgent Care Benefits

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.

5.4 Mental Health, Alcohol and Drug Abuse Services Benefits

The Health Plan covers mental health, alcohol and drug abuse services when listed on the Schedule of Benefits or when a Mental Health and Substance Abuse Rider is purchased. CHC may contract with an outside vendor to coordinate, determine Medical Necessity of and Pre-Authorize the diagnosis and treatment of all biologically based mental illnesses, psychiatric conditions, and substance abuse ("Mental Health and Substance Abuse"). Prior Authorization for Mental Health and Substance Abuse must be obtained through the contracted vendor. The vendor and its telephone number are listed on Your ID card, the CHC Website and in the Directory of Health Care Providers.

If You have any questions about Your Mental Health and Substance Abuse Coverage or the appropriate way to access Coverage, please contact the CHC website, the mental health vendor or CHC at (800) 257-4692. Please see your

Mental Health and Substance Abuse Benefit Rider for detail of all Your Mental Health and Substance Abuse benefits.

5.5 Prescription Drugs

The Health Plan covers prescription drugs when a Prescription Drug Rider is purchased.

If the medication prescribed is not listed in the CHC formulary, the pharmacist can contact Your physician to have the prescription rewritten in compliance with the Formulary. See Your Prescription Drug Benefit Rider for detail of all Your pharmacy benefits.

5.6 Transplant Services

Services related to Medically Necessary organ transplants (solid organ or bone marrow) are Covered when approved by Us and performed at a Coventry Transplant Network Facility.

Donor screening tests are Covered and are subject to a benefit maximum of $10,000 when performed at a Coventry Transplant Network Facility approved by Us.

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.

Travel expenses for Members and living donors are covered according to the Coventry Health Care transplant travel benefit. Members are covered when the Health Plan is the primary insurer and a Coventry Transplant Network Facility approved by Us is used. Transplant Services are continually updated due to advances in medicine and technology and proved efficacy by the Health Plan.

SECTION 6
EXCLUSIONS AND LIMITATIONS

6.1 The Health Plan does not cover the following items, unless covered in a rider or Your Schedule of Benefits:

6.1.1 Any service, supply, equipment, drug or procedure that is not provided or arranged and coordinated through Participating Providers in accordance with Our utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Agreement;

6.1.2 Any service, supply, equipment, drug, or procedure that is not Medically Necessary;

6.1.3 Any service, supply, equipment, drug, or procedure that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service;

6.1.4 Any service, supply, equipment, drug, or procedure for the treatment of smoking cessation;

6.1.5 Any service, supply, equipment, drug, or procedure for which You have no financial liability or that was provided at no charge;

6.1.6 Non-emergency services provided outside the Service Area, including elective care, obstetrical services (after 37 weeks of pregnancy), follow-up care of an illness or injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area;

6.1.7 Any service, supply, equipment, drug, or procedure furnished under or as part of a study, grant, or research program or that we determine, in our sole and absolute discretion to be Experimental or Investigational;

6.1.8 Any service, supply, equipment, drug, or procedure rendered or utilized as a result of injuries sustained during the commission of an illegal act;

6.1.9 Court-ordered services or services that are a condition of probation or parole.

6.2 Specifically Excluded services/items, unless covered in a rider or Your Schedule of Benefits:

6.2.1 Acupuncture, accupressure;

6.2.2 Alternative therapies;

6.2.3 Ambulance service for non-emergencies;

6.2.4 Any item or technology requiring federal or other government agency approval that has not been granted at the time services are rendered;

6.2.5 Any portion of the cost for unauthorized services;

6.2.6 Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

6.2.7 Behavior modification;

6.2.8 Biofeedback;

6.2.9 Braces and supports needed for athletic participation or employment;

6.2.10 Breast augmentation and reduction;

6.2.11 Breast reconstruction which is not associated with the Women's Health and Cancer Rights Act;

6.2.12 Breast pumps;

6.2.13 Care rendered to You by a relative;

6.2.14 Charges resulting from Your failure to appropriately cancel a scheduled appointment;

6.2.15 Cochlear Implants;

6.2.16 Complications that result from not following the course of treatment prescribed by a Participating Provider;

6.2.17 Cosmetic services and surgery and the complications incurred as a result of those services and surgeries;

6.2.18 Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, convalescent care, and respite care;

6.2.19 Day care;

6.2.20 Dental care, appliances, implants, crowns, bridges, dentures, or other prosthetic devices, dental restorative care, periodontal care, treatment of impacted wisdom teeth, orthodontics, treatment for temporomandibular joint dysfunction (TMJ), 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, or the alveolar process of the gums;

6.2.21 Disposable items;

6.2.22 Dynamic Orthotic Cranioplasty (DOC) Bands, Cranial Orthosis, Molding Helmet Therapy, or surgical treatment of deformational plagiocephaly;

6.2.23 Educational testing or psychological testing, unless part of a treatment program for Covered Services;

6.2.24 Emergency room services for non-emergencies;

6.2.25 Exams for employment, school, camp, sports, licensing, insurance, adoption, or marriage;

6.2.26 Exercise equipment, rental or purchase;

6.2.27 Eye examinations for refractive correction unless listed in the Schedule of Benefits;

6.2.28 Eye exercises and therapy; fitting or cost of visual aids;

6.2.29 Eye glasses, corrective lenses and sunglasses, except as necessary for the initial placement of corrective or contact lenses following cataract surgery performed while a Member of the Plan;

6.2.30 Food and food supplements, including but not limited to, infant formulas;

6.2.31 Foot orthotics (e.g., shoe inserts, special shoes);

6.2.32 Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities;

6.2.33 Hair analysis, hair prostheses, wigs and hair transplants;

6.2.34 Health services resulting from war or an act of war;

6.2.35 Hearing aids and associated audiometric services (including the cost and fitting);

6.2.36 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;

6.2.37 Humidifiers, de-humidifiers, air-conditioners, space heaters, or any other equipment or service used in altering air quality or temperature;

6.2.38 Immunizations for travel or employment;

6.2.39 Infertility treatment including services, supplies, equipment, procedures and drugs;

6.2.40 Learning disabilities treatment;

6.2.41 Long-term care and all services provided by such facilities;

6.2.42 Marriage or relationship counseling, family counseling, vocational or employment counseling, sex therapy, and sex counseling;

6.2.43 Maternity services outside the Service Area within three (3) weeks of the estimated date of delivery;

6.2.44 Mental health services unless listed on the Schedule of Benefits;

6.2.45 Newborn home delivery and birthing centers;

6.2.46 Oral Surgery if required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthoganathic or prognathic surgical procedures, involving removal of symptomatic bony impacted third molars;

6.2.47 Orthodontia, orthodontic braces and related services;

6.2.48 Over-the-counter supplies and drugs such as, but not limited to, ACE wraps, elastic supports, finger splints, wrist splints and orthotics;

6.2.49 Patient lifts, including but not limited to chair lifts, seat lifts, vehicle lifts and bed lifts;

6.2.50 Penile prostheses;

6.2.51 Personal comfort and convenience items such as but not limited to, television, telephone, tissue, razor, toothbrush, toothpaste, air mattress, corsets and clothing;

6.2.52 Prescription drugs unless listed in the Schedule of Benefits;

6.2.53 Private duty nursing;

6.2.54 Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable;

6.2.55 Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school;

6.2.56 Psychoanalysis;

6.2.57 Radial keratotomy, laser eye surgery or similar surgery done to treat myopia;

6.2.58 Removal of skin lesions, unless lesions interfere with normal bodily functions, or a malignancy is suspected;

6.2.59 Retroactive Referrals;

6.2.60 Routine foot care, removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, and chronic foot strain;

6.2.61 Self-Administered Injectable Drugs covered by the Pharmacy or Self-Administered Injectable Drug Rider;

6.2.62 Self-inflicted (intentional) injury or sickness, suicide, or suicide attempt whether sane or insane;

6.2.63 Services that are paid by, or recovered amounts specifically for, medical expenses from a third party or insurance carrier;

6.2.64 Services the Member is entitled to under Medicare even if the Member is not enrolled;

6.2.65 Sex transformation procedures, treatments, or studies;

6.2.66 Short-term therapy that exceeds the limits listed in the Schedule of Benefits;

6.2.67 Sterilization reversal and any service, supply, equipment, drug, or procedure related to surrogate childbirth, egg or sperm donation, cryopreservation, in vitro fertilization, artificial insemination, and storage of sperm, eggs and embryos;

6.2.68 Surgery performed solely to address psychological or emotional factors;

6.2.69 Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

6.2.70 Take-home drugs;

6.2.71 Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating an organ or tissue to a non-covered individual;

6.2.72 Travel expenses (except as provided in Section 5.6, Transplant Services);

6.2.73 Treatment for behavioral conditions not attributable to a Mental Disorder described in the Diagnostic and Statistical Manual Published by the American Psychiatric Association as "V" codes, such as but not limited to, relational problems, anti-social behavior, academic problems and phase-of-life problems;

6.2.74 Treatment for delirium, dementia, amnesia or cognitive disorders with psychiatric manifestations or conditions;

6.2.75 Treatment of mental retardation, unless covered as a biologically-based mental illness;

6.2.76 Treatment for disorders relating to: learning, motor skills, communication, pervasive developmental conditions such as, but not limited to, autism, feeding and eating in infancy and early childhood;

6.2.77 Treatment for substance abuse (except as provide in Section 5.4);

6.2.78 Treatment received outside Our Service Area, which could reasonably have been foreseen by a Member prior to departure from Our Service Area;

6.2.79 Vision care and optometric services;

6.2.80 Vocational therapy;

6.2.81 War related sickness, injury, and services 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;

6.2.82 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, gastric bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature;

6.2.83 Whole blood and blood products replacement to a blood bank;

6.2.84 Work hardening programs; and

6.2.85 Work related injuries or illnesses.

6.3 Exclusion of Coverage for Pre-existing Medical Conditions

- We may exclude Coverage for Pre-existing Medical Conditions if provided for in the Group Contract. Any exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, an individual licensed or similarly authorized to provide such services under applicable state law within the six (6) month period prior to the Enrollment Date.

For purposes of this section only, the "Enrollment Date" is the earlier of: (1) the first (1st) day of Coverage under this Agreement: or (2) if the Group Contract imposes a waiting period, the (1st) day of the waiting period. If there is a waiting period, the Pre-existing Medical Condition exclusion period is offset by the period of time beginning with the first (1st) day of the waiting period and ending of the first (1st) day of Coverage under this Agreement.

Except in the case of a Late Enrollee, the exclusion period for Pre-Existing Medical Conditions ends no later than twelve (12) months after the enrollment date (eighteen (18) months in the case of a Late Enrollee). The exclusion period will be reduced by Your Prior Period of Creditable Coverage. A Prior Period of Creditable Coverage is the number of days credited to a Member that operates to reduce or eliminate the Health Plan's Pre-existing Medical Condition exclusion period.

Note: The Health Plan will not impose a Pre-existing Medical Condition exclusion period for pregnancy or on a newborn, a child under eighteen (18) years of age who is adopted or legally placed for adoption, provided the child is Covered under this Agreement within thirty-one (31) days of birth, adoption, or placement for adoption. However, if the child has a significant break in creditable Coverage of at least sixty-three (63) consecutive days, the Health Plan may impose a Pre-existing Medical Condition exclusion period on the child.

6.4 Certification of Creditable Coverage – For purposes of applying the Pre-existing Medical Condition exclusion pursuant to Section 6.3 of this Agreement, the following terms will apply:

6.4.1 Before the Health Plan imposes an exclusion period with respect to any Member we will provide notice to You of the existence and terms of the Pre-existing Medical Condition exclusion. This notice will include: (a) a description of the affected Member's right to demonstrate "prior creditable Coverage;" (b) a description of the affected Member's right to request a "certificate of creditable Coverage" from a prior health insurance plan; and (c) a statement that the Health Plan will assist the affected Member in obtaining such a certificate from any prior health insurance plans.

6.4.2 Once the affected Member submits one or more certificates of Coverage concerning prior health Coverage, the Health Plan will determine how much of the Coverage documented therein must be applied towards satisfying the Health Plan's Pre-existing Medical Condition exclusion period.

6.4.3 If the accuracy of a certificate is contested by Us, or a certificate is unavailable when needed, an individual has the right to demonstrate creditable Coverage by alternate means. This right exists under the following circumstances: (a) an entity failed to provide (or timely provide) the Member a certificate; (b) the Member is not entitled to a certificate from a prior entity (such as when the Member's Coverage with a prior health insurance plan is for a period before July 1, 1996); or (c) the Member needs to demonstrate creditable Coverage before a certificate is available (such as when the Member has an urgent medical condition that necessitates an immediate determination of his or her creditable Coverage).

We are required to consider all information that We obtain or that is presented to Us in making a determination, based on the relevant facts and circumstances, whether a Member has creditable Coverage. We will treat the Member as having furnished a certificate with respect to his or her own creditable Coverage and with respect to the creditable Coverage of any Dependents if the member: (a) attests to the period of creditable Coverage; (b) presents relevant corroborating evidence of some creditable Coverage during the relevant period; and (c) cooperates with Our efforts to verify the information, including giving Us authorization to request a certificate from a prior health insurance plan on the Member's behalf.

A Member may use the following types of documentation as corroborating evidence of creditable Coverage during the relevant period: (a) an explanation of benefits (EOB) or other correspondence from a health insurance carrier establishing prior Coverage; (b) pay stubs showing a deduction for health plan Coverage; (c) a health insurance identification card; (d) a certificate of Coverage from the prior health insurance plan; (e) records from a health care provider demonstrating prior Coverage; (f) third (3^{rd}) party statements verifying periods of Coverage, including information received from the prior health insurance plan over the telephone; and (g) any other relevant documents that evidence periods of health Coverage.

6.4.4 Within a reasonable time following receipt of creditable Coverage information from the Member, We will make a determination, based on the facts and circumstances as to whether the individual has creditable Coverage and what portion (if any) of our Pre-existing Medical Condition exclusion period will apply to the affected Member. Before We will impose a pre-existing exclusion period upon the Member, We will notify the Member of the determination and of the applicable appeals process.

6.4.5 After an affected Member has submitted a certificate of creditable Coverage (or other acceptable alternative documentation) to Us, We will notify the affected Member in writing (within a reasonable period of time) of Our determination regarding how much of Our Pre-existing Medical Condition exclusion period will be applied to that particular affected Member. The written notice will include: (a) the basis for Our determination; (b) the source and substance of any information on which the Health Plan relied; and (c) an explanation of the procedures established by Us for the individual to appeal the decision regarding the Pre-existing Medical Condition exclusion period. (NOTE: We will not provide this second notice if We determine that the Plan's Pre-existing Medical Condition exclusion period has been "zeroed-out" and does not apply to the Member, due to the length of the Member's prior creditable Coverage). In addition to the written notice described in this section, We will provide the Member with a reasonable opportunity to submit additional evidence of creditable Coverage. However, if We subsequently determine that the Member did not have the claimed creditable Coverage, We can modify our initial determination provided that: (a) the notice advises the Member of the right to reconsideration; and (b) until the final determination is made, We act in a manner consistent with the initial determination for the purpose of approving access to medical services.

SECTION 7
COORDINATION WITH OTHER COVERAGE
(COORDINATION OF BENEFITS-COB)

7.1 Coordination With Other Plans

While eligible for Coverage with Us, You may have other Coverage for the same services or supplies. Coordination of Benefits is a procedure that prevents duplicate payment under this Agreement and any other arrangements You may have. When CHC is the primary health plan, then CHC pays first for all Covered Services. When secondary, CHC makes payment according to the provisions and benefit levels of this plan, after the primary health plan has paid according to its agreement.

7.2 Definitions

7.2.1 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.

7.2.1.1 "**Plan**" includes: group insurance, closed panel or other forms of group or group-type Coverage, hospital indemnity benefits in excess of $200 per day, medical care components of group long-term care contracts, medical benefits under group or individual automobile contracts, and Medicare or other governmental benefits as permitted by law and subject to the rules on COB with Medicare set forth below.

7.2.1.2 "**Plan**" does not include: individual or family insurance, close panel or other individual Coverage, amounts of hospital indemnity insurance of $200 or less per day, school accident type Coverage, benefits for non-medical components of group long-term care policies, Medicare supplemental policies, Medicaid policies and Coverage under other governmental Plans, unless permitted by law.

7.2.1.3 Each contract for Coverage under Section 7.2.1.1 or 7.2.1.2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

7.2.2 The order of benefit determination rules determine whether We are a "**Primary**" Plan or "**Secondary**" Plan when compared to another Plan covering You or Your Covered Dependents. 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 because of the Primary Plan's benefits.

7.2.3 "**Allowable Expense**" means a health care service or expense including deductibles and copayments, that is covered, at least in part by any of the Plans covering You or Your Covered Dependent. 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 or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

7.2.3.1 If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is otherwise Covered) is not an Allowable Expense.

7.2.3.2 If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

7.2.3.3 If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plan.

7.2.3.4 The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions.

7.2.4 "**Claim Determination Period**" means a Calendar Year. However, it does not include any part of a year during which a Member has no Coverage under this Health Plan, or before the date this COB provision or a similar provision takes effect.

7.2.5 "**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.

7.2.6 "**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.

7.3 Order of Benefit Determination Rules

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

7.3.1 The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

7.3.2 A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary. There is one exception: 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.

7.3.3 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.

7.3.4 The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

7.3.4.1 **Non-Dependent or Dependent** . The Plan that covers the Member other than as a dependent 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 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.

7.3.4.2 **Child Covered Under More than One Plan**. The order of benefits when a child is covered by more than one Plan is:

i. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care Coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.

ii. If the specific terms of a court decree state that one of the parents is responsible for the 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 Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

iii. If the parents are not married, or are separated or are divorced, the order of benefits is:

- the Plan of the Custodial Parent;
- The Plan of the spouse of the Custodial Parent;
- The Plan of the non-custodial parent; and then

- The Plan of the spouse of the non-custodial parent.

7.3.4.3 **Active or inactive Employee**. The Plan that covers a Member as an Employee who is neither laid off nor retired is Primary. The same would hold true if a Member is a dependent of a person covered as a retiree and an Employee. 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.

7.3.4.4 **Continuation Coverage**. If a Member whose Coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the Member as an Employee, member, subscriber or retiree is Primary, and the continuation Coverage is Secondary. 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.

7.3.4.5 **Longer or shorter length of Coverage**. The Plan that covered the Member as an Employee, member, subscriber or retiree longer is Primary.

7.3.4.6 If the preceding rules do not determine the Primary Plan the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, We will not pay more than we would have paid had We been Primary.

7.4 Effect On The Benefits of this Health Plan

7.4.1 When We are Secondary, we may reduce Our benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more that 100 percent of total allowable expenses. The difference between the benefit payments that We would have paid had We been the Primary Plan, and the benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by Us to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted We will:

7.4.1.1 Determine Our obligation to pay or provide benefits under this contract;

7.4.1.2 Determine whether a benefit reserve has been recorded for You or Your Covered Dependent; and

7.4.1.3 Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Member's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claims Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

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.

7.5 Coordination of Benefits with Medicare

7.5.1 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 Calendar 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 Calendar 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.

7.5.2 Disability

If You are under age 65 and eligible for Medicare due to disability, and actively work for 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.

7.5.3 End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. If this Health Plan is currently paying benefits as secondary, this Health Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

7.5.4 Coordination of Benefits for Retirees

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 Agreement will be paid after:

7.5.5 Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;

7.5.6 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

7.5.7 Amounts paid under all other plans in which You participate.

7.6 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

- Provide Us with information about other Coverage and promptly notify Us of any Coverage changes;
- Give Us the right to obtain information as needed from others to coordinate benefits;
- Return any excess amount to Us if We make a payment and later find that the other Coverage should have been primary.

SECTION 8
CONTINUATION OF COVERAGE

8.1 Continuation Of Coverage for Certain Subscribers and Dependents

You are eligible to retain Coverage under this Certificate during any continuation of Coverage period required under applicable federal or state law or regulation, provided that during such required continuation of Coverage period You comply with the terms and conditions of the Group Contract and the premiums for such Coverage continue to be paid by the Group pursuant to the terms of the Group Contract, COBRA and any other applicable federal or state law or regulation.

Coverage shall terminate at the end of the minimum period of time required by COBRA or other applicable federal or state law or regulation.

You should contact the Group for the answers to any questions You have with respect to Continuation of Coverage.

You should also refer to Section 9 for any conversion privilege You may have at the end of any period of continuation Coverage

8.1.1 Continuing Group Coverage Under Federal Law

Under federal law, an Employer who has more than twenty (20) Employees is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA requires an Employer to offer, to the Subscriber and Dependents, the option to continue the group Coverage for up to eighteen (18) months for one of the following qualifying events:

- The Subscriber's employment is terminated for any reason other than gross misconduct;
- Reduction in the Subscriber's scheduled work hours (e.g., change from full-time to part-time, lay off, leave of absence, etc.); or
- 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.

Coverage may be continued for the Subscriber and Dependents for up to eighteen (18) months. If the Subscriber is disabled, as defined by Social Security, 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:

- Divorce;
- Legal Separation;
- Attainment of the Limiting Age;
- The Subscriber's death; or
- The Subscriber becomes eligible for Medicare.

You have sixty (60) days from the date You receive notification from the Employer to elect COBRA Coverage. The Employer may require You to pay the full cost of the COBRA Coverage.

COBRA ends when:

- The maximum continuation period ends;
- The Employer ceases to provide any group health plan for any Employee;
- The required Premium is not paid when due;
- Coverage under another group health plan that does not include a Pre-Existing Condition clause begins; or
- The Member becomes Covered under Medicare.

Certificates of Coverage will be sent to all affected individuals who lose Coverage under a plan. The law describes three events that trigger Certificates of Coverage. Certificates must be sent:

- Automatically upon a loss of Coverage for any reason, under a plan (including due to a COBRA Qualifying Event (QE));
- Automatically upon loss of COBRA Coverage;
- At any time upon an individual's request within 24 months after Coverage under the plan ends.

This explanation is not a legal opinion, but merely a general summary of Your continuation of Coverage rights under COBRA. The Employer is responsible for the administration of COBRA Coverage. It is important to note that the Internal Revenue Service may change or amend COBRA from time-to-time.

8.1.2 Continuing Group Coverage Under State Law

Under Iowa law, an Iowa Employer not subject to COBRA continuation legislation must offer to continue the group's current Coverage to:

(1) Subscribers whose Coverage would otherwise terminate because of involuntary termination of employment for reasons other than misconduct;

(2) An eligible Dependent whose Coverage would otherwise terminate due to divorce from the Subscriber; and

(3) An eligible Dependent whose Coverage would otherwise terminate due to death of a Subscriber.

The Subscriber or eligible Dependent who elects to continue group Coverage must request continuation in writing to the Employer within the ten (10) day period following the later of the following:

- The date of termination; or
- The date the Employer gives the Member notice of the right of continuation.

If proper notification is given, the Member is not eligible to elect continuation of group Coverage more than thirty-one (31) days after the date of termination.

The Subscriber of eligible Dependent must pay the entire monthly Premium payments. The first (1st) month's premium should be paid to the Employer at the same time the Employer is informed of the Subscriber's decision to elect continued group Coverage. Thereafter, the Subscriber or eligible Dependent must pay monthly Premium payments in advance to the Employer.

Under Iowa law, a Subscriber or eligible Dependent is eligible for nine (9) months of continued group Coverage if he or she meets all of the following requirements:

- He or she has been Covered under this Group Master Contract or any prior group contract replaced by the Group Master Contract during the entire three (3) month period before termination;
- He or she is not and does not become eligible for Medicare Coverage; and
- He or she is not and does not become eligible for any Hospital, Physician and/or major medical Coverage under any other group health benefit program or plan written on an expense incurred basis or with an HMO.

Under Iowa law, the continued group Coverage ends at the earliest of the following:

- When the Dependent ceases to be eligible as defined above;
- Nine (9) months after the date the group Coverage would have otherwise terminated;
- When the divorced Spouse remarries;
- The date of expiration of the period for which Premiums were paid, in the event of nonpayment of Premiums; or
- The date on which the Group Master Contract is terminated.

SECTION 9
CONVERSION

If Your eligibility for group health Coverage ends under this Agreement, You may convert to a non-group Coverage on a direct-pay basis ("Conversion Coverage"). You will not have to provide proof of insurability. However, if the benefits under the Conversion Coverage are greater than the benefits under this Agreement, You may be asked to provide evidence of insurability for the greater benefits. You must apply for direct pay Coverage within thirty-one (31) days after You lose group eligibility. Contact the Customer Service Department at (800) 257-4692 for information regarding conversion. The first premium must be received before Conversion Coverage will be put in force. Conversion Coverage will then be effective on the date the group Coverage ends. In some cases, a Member can choose to continue group Coverage for a period of time. In such a case, Conversion Coverage would be available after Group Coverage ends.

9.1 Converting to Individual Conversion Coverage

When, and only when, a Member becomes ineligible for or has exhausted the group Coverage provided under this Agreement, the Member may convert to individual conversion Coverage. The Member must send to Us an application for individual conversion Coverage within thirty-one (31) days following the later of the following:

- The date the group Coverage terminated; or
- The date We notified the Member of the right to convert.

In the event a Member has not received proper notice of the right to convert to individual conversion Coverage, he or she can still apply. To do so, the Member must apply within ninety (90) days following the date the group Coverage ended. The Member's application must include payment for three (3) months' Coverage at the individual conversion Premium in effect at that time. Members will be billed quarterly after the initial payment. A Member may obtain an application and Premium amounts for individual conversion by writing to Us. Individual conversion Coverage is subject to periodic changes in Premium as determined by Us. Members will receive notice within thirty-one (31) days of any changes in Premium. The Member will not be allowed to convert to individual conversion Coverage if any of the following occurs:

- Group Coverage available under this Agreement ended because of nonpayment of Premium, Copayments, Coinsurance and Deductibles;
- The Member no longer resides or works in the Service Area;
- Group Coverage available under this Agreement ended because of the unreasonable refusal to accept services; or
- Group Coverage available under this Agreement ended because of fraudulent use of the Member's Health Plan identification card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to Enroll non-eligible persons as Dependents.

SECTION 10
RESOLVING 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.

10.1 Definitions of Terms Used in This Section

The following terms and definitions apply:

10.1.1 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).

10.1.2 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.

10.1.3 Appeal – An Appeal is a request by the Member or Member's Authorized Representative for consideration of an Adverse Benefit Determination of a health service request benefit, or benefit payment that the Member believes he or she is entitled to receive.

10.1.4 Adverse Benefit Determination – A denial of a request for Coverage of a service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of Coverage for a Covered Service. An Adverse Benefit Determination includes the failure to cover services because they are determined to be experimental, investigational, not necessary based in whole or in part to a medical judgment or inappropriate.

10.1.5 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.

10.1.6 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.

10.1.7 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.

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.

10.2 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 Covered Services, he/she may contact a Customer Service Representative telephonically at **1-800-257-4692**, or in writing, expressing the details of the Member's dissatisfaction to file a Complaint. The objective is to handle the Complaint as quickly and as courteously as possible.

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 a written Appeal with Us to the address below. The request for Appeal must include:

- ✓ Patient name and number;
- ✓ 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 (e.g., emergency details, date, time, symptoms, why the Member did not contact their Physician); and
- ✓ Clear indication of the reason for dissatisfaction.

The written request for an appeal 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 received after the 180 calendar day period will not be eligible for review under the Health Plan's internal appeal process.

Our address and phone number are as follows:

Coventry Health Care of Iowa, Inc.

4600 Westown Parkway, Suite 200

West Des Moines, Iowa 50266

800-257-4692

10.3 Pre-Service Appeal Process

All Pre-Service Appeals will allow You or Your 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. The Member may opt for a thirty (30) calendar day extension in order to allow time to gather documentation that they feel is pertinent to their case.

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

10.4 Post-Service Appeal Process

First Level Appeal – A Member's written request of Appeal will be presented for review to the First Level Appeals Committee. We shall notify the Member in writing within thirty (30) calendar days following the request for an appeal of the panel's final decision. The Member may opt for a thirty (30) calendar day extension in order to allow time to gather documentation that they feel is pertinent to their case.

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 Member is encouraged to present their case to the Committee and will be notified of the Committee's final decision within thirty (30) calendar days following the request. The Member may opt for a thirty (30) calendar day extension in order to allow time to gather documentation that they feel is pertinent to their case.

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.

10.5 Urgent Care Appeals

In situations involving Urgent Care Appeals, We shall notify the Member of Our determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the request for review of an Adverse Benefit Determination.

10.6 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 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.

SECTION 11
ACCESS TO RECORDS AND CONFIDENTIALITY OF INFORMATION

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

- claims processing, including claims 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 service You, we need information about You. This information may come from You, Your employer, 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 You 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 12
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 in 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 most 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 13
DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

13.1 "Actively at Work"

An Employee performing all regular duties on a regularly scheduled work day:

- at the location where the duties are normally performed; and
- On a full-time basis.

An Employee may be considered Actively at Work on a non-scheduled work day, but only if Actively at Work on the preceding scheduled work day. Additional consideration may be given on a case by case basis in order to comply with the provisions of the Family and Medical Leave Act of 1993.

13.2 "Agreement"

The Evidence of Coverage (EOC), amendments and addendums, the Enrollment Form, the Schedule of Benefits, applicable Riders, and the Group Master Contract together form the Agreement.

13.3 "Authorize/Pre-Authorize/Authorization/Prior Authorization/Authorized"

CHC has given approval for payment for certain services to be performed. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

13.4 "Calendar Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated.

13.5 "Coinsurance"

The amount, calculated using a fixed percentage, You pay each time You receive certain covered services.

13.6 "Contract Year"

The contract year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary.

13.7 "Copayment"

The Member's responsibility for a dollar amount per service; specified in this Agreement.

13.8 "Cosmetic Services and Surgery"

Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

13.9 "Coventry Transplant Network Facility"

A facility that directly or indirectly has a contract with the Health Plan and is designated for particular transplants or other treatment modalities.

13.10 "Cover" or "Covered" or "Coverage"

The entitlement by a Member to Covered Services under the Evidence of Coverage, subject to the terms, conditions, limitations and exclusions of the Evidence of Coverage, including the following conditions: (a) health services must be provided when the Evidence of Coverage is in effect; and (b) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Evidence of Coverage occur; (c) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Evidence of Coverage; (d) health services must be Medically Necessary and (e) health services listed in Section 5 "Covered Services" of this Evidence of Coverage.

13.11 "Covered Services"

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

13.12 "Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying before benefits subject to the Deductible are payable under this Agreement.

13.13 "Dependent"

Any Member of a Subscriber's family who meets the eligibility requirements as outlined in this Agreement.

13.14 "Effective Date / Member Effective Date"

The date entered on Our records as the date when Coverage for a Member under this Agreement begins in accordance with the terms of this Agreement, which Coverage shall begin at 12:01 a.m. on such date.

13.15 "Emergency Medical Condition"

An Emergency Medical Condition is the sudden onset of acute symptoms of sufficient severity (including pain) which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

13.16 "Emergency Out of Area"

Covered Services provided when an enrollee is temporarily absent from the Service Area, that are immediately required as a result of:

1. an unforeseen illness, injury, or condition; and
2. it is not reasonable given the circumstances to obtain services through a CHC Participating Provider.

13.17 "Emergency Services"

Covered inpatient and outpatient health care services that are:

1. rendered by a Provider qualified to provide Emergency Services; and
2. necessary to evaluate or stabilize an Emergency Medical Condition.

13.18 "Employee(s)"

One who works for the Employer and receives wages or a salary.

13.19 "Employer"

The company with whom the Health Plan has a signed Group Master Contract to provide Subscribers and their Dependents the Covered Services under the terms of this Agreement.

13.20 "Enroll (Enrollment, Enrolled)"

To apply for Covered Services under this Agreement and be accepted by the Health Plan.

13.21 "Enrollment Form"

The application for enrollment in the Health Plan.

13.22 "Enrollment Date"

The first day of Coverage under a plan or if there is a waiting period, the first day of the waiting period.

13.23 "Excluded"

Not Covered under this Agreement.

13.24 "Experimental or Investigational"

A health product or service is deemed experimental (or investigational) if one or more of the following criteria are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations;
- Any health product or service that is not considered standard treatment by the medical community, based on clinical evidence reported in Peer-Review Medical Literature and by generally recognized academic experts.

13.25 "Formulary"

A listing of prescription drugs approved by CHC for Coverage under this Agreement. These are dispensed through a pharmacy to Members. This list is subject to periodic review and change by CHC. The Formulary is available for review in Participating Provider offices, the CHC Website or by contacting the Customer Service Department.

13.26 "Full-time Student"

A Dependent Child:

- Under the age of twenty-four (24),or other age as defined in the Group Master Contract; and
- Enrolled in and attending at least twelve (12) credit hours per semester (or full-time, as defined by the school) in a recognized course of study in a secondary school, college, university, or licensed trade school, and capable of providing a Registrar's letter, or equivalent documentation upon request.

Full-time status continues during:

- Regularly scheduled school vacation periods;
- Absence from enrolled classes for up to four (4) months due to disability (proof of disability must be provided upon request); and
- Temporary residence outside the Service Area to attend school.

13.27 "Group"

An organization or firm contracting with CHC to arrange health care services for Subscribers and their Dependents through which eligible Subscribers and Dependents become entitled to the Covered Services described herein.

13.28 "Group Master Contract"

The agreement between the Group and Us that states the agreed upon contractual rights and obligations of CHC, the Group, and the Members.

13.29 "Group Effective Date"

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

13.30 "Group Enrollment Period"

Shall mean a period of time occurring annually during which time any eligible Employee may enroll with CHC for Coverage under this Evidence of Coverage. If an Employee has previously waived Coverage under this Agreement it will remain at the discretion of the Group to allow them to elect Coverage during the next Group Enrollment Period.

13.31 "Health Plan"

Coventry Health Care of Iowa, Inc. (CHC)

13.32 "Hospice"

A program that provides care in a comfortable setting (usually the home) for patients who are terminally ill and have a life expectancy of six months or less.

13.33 "Hospital"

A corporation providing hospital related services and duly licensed by the State of Iowa. Such corporation must possess all State required licenses, have evidence of Medicare/Medicaid certification, appropriate malpractice insurance Coverage, certified under Title XVIII and Title XIX of the Social Security Act and is in good standing with State and Federal regulatory bodies. The Corporation must be accredited by either Joint Commission on Accreditation of Health Care Organizations (JCAHO), American

Osteopathic Association (AOA), or have had a current State review from the Iowa Department of Health & Human Services.

13.34 "Infertility"

Infertility means the inability of a woman to conceive a pregnancy after six months of unprotected intercourse or the inability of a woman to carry a pregnancy to live birth.

13.35 "In-Network"

Medically Necessary health care services provided to Members by Participating Providers under contract with the Health Plan.

13.36 "Late Enrollees"

Shall mean individuals who fail to enroll with CHC for Coverage under the Agreement during the required thirty-one (31) day period when they first become eligible for Coverage. This term does not include Special Enrollees.

13.37 "Maximum Lifetime Benefit"

The maximum amount of Health Plan coverage allowed to a specific enrolled Member in his or her lifetime.

13.38 "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.

13.39 "Medically Necessary"

Medically Necessary services and/or supplies provided to a Member that are determined by the Health Plan to be;

- Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
- Necessary to meet the basic health needs of the Member as a minimum requirement;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- 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 accepted by the plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the comfort or convenience of the covered person or his or her physician; and,
- Of demonstrated value based on clinical evidence reported by Peer Reviewed Medical Literature and by generally recognized academic medical experts; that is, it is not Experimental or Investigational.

13.40 "Member"

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA or State Continuation) who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

13.41 "Non-Participating Provider"

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

13.42 "Nursing Facility"

An institution that is:

- Accredited as a Nursing Facility by the Joint Commission on Accreditation of Health Care Organizations;
- Recognized and eligible for payment under Medicare as a Nursing Facility; and
- Recognized by the Health Plan.

13.43 "Out-of-Network"

Any health care services that are provided by a Non-Participating Provider.

13.44 "Out-of-Network Rate"

The maximum amount covered by Us for approved Out-of-Network services. This rate will be derived from either a Medicare based fee schedule or a percent of billed charges as determined by Us. You are responsible for Charges that exceed our Out-of-Network Rate for Non-Participating Providers. This could result in You having to pay a significant portion of Your claim. Balances above the Out-of-Network Rate do NOT apply to Your Out-of-Pocket Maximum. Please feel free to contact the Plan regarding the Out-of-Network Rate methodology.

13.45 "Participating Provider/Provider Network"

A Provider who has entered into a direct or indirect written agreement with Us to provide Covered Services to Members. The participation status of Providers may change from time to time.

13.46 "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.

13.47 "Peer-Reviewed Medical Literature"

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

13.48 "Pre-Existing Medical Condition"

Any medical condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed Provider within six (6) months immediately preceding the Member's Enrollment Date under the Agreement.

13.49 "Premium"

The payment to the Health Plan, made by Members or the Employer, before obtaining Covered Services.

13.50 "Provider(s)"

A Physician, Hospital, 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.

13.51 "Retiree"

Shall mean a former Employee of the Group who meets the Group's definition of retired Employees as defined in the Group Master Contract.

13.52 "Rider"

A document that supplements the Schedule of Benefits.

13.53 "Self-Administered Injectable Drugs"

Self-Administered Injectable Prescription Drugs, as defined by the Plan, that are commonly and customarily administered by the Member, and are dispensed only by the Specialty Pharmacy, or other Pharmacy designated by the Health Plan. Examples of Self-Administered Injectable Prescription Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Other self-administered injectable drugs, that are acquired through the Retail Pharmacy, are not considered Self-Administered Injectable Prescription Drugs, such as: insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives.

13.54 "Service Area"

The geographical area defined by the Health Plan and approved by the appropriate regulatory agency.

13.55 "Short-Term Therapy"

Medically Necessary to restore normal physical function or impairment due to trauma, stroke, a surgical procedure, or other acute condition, and when significant improvement can be achieved within sixty (60) consecutive days from the onset of treatment.

13.56 "Specialty Pharmacy"

A pharmacy that directly or indirectly has a contract with the Health Plan and is designated as a Specialty Pharmacy by the Health Plan for certain Prescription Orders or Refills.

13.57 "Subscriber"

The eligible Employee, Retiree or qualified beneficiary (as that term is defined under COBRA and State Continuation) who has elected CHC Coverage for himself and any eligible Dependents through submission of an Enrollment Application and for whom, or on whose behalf, premiums have been received by Us.

13.58 "We/Us or Our"

The Health Plan.

13.59 "You/Your"

A Member covered under this Evidence of Coverage.

SECTION 14
GENERAL PROVISIONS

14.1 Applicability

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

14.2 Choice of Law

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

14.3 Clerical Error

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

14.4 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 the Agreement conflicts with the requirements of federal or state law, the 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.

14.5 Entire Agreement

This Agreement shall constitute the entire Agreement between the parties. 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. No such statement which is made to effectuate Coverage of a Member shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease Benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

14.6 Events Beyond Control

If a natural disaster, riot, civil insurrection, epidemic or any similar event not within Our control results in Our being unable to provide or arrange for the Covered Services under this Agreement, We are required to make a good-faith effort to provide or arrange for Covered Services, considering the impact of the event. We will be liable to reimburse the expenses for Medically Necessary Covered Services under this Agreement, as prescribed by the Iowa Insurance Division.

14.7 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.

14.8 Nontransferable

No person other than You 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.

14.9 Payment to Providers

Payment for Covered Services will be made by Us directly to the Participating Provider. For Emergency Services and Urgent Care services, payment will be made by Us directly to the Provider or may, at Our discretion, be made to You. Participating Providers may not, under any circumstances, seek payment from You except for Copayments, Coinsurance, Deductibles and payments for non-Authorized or non-Covered Services.

14.10 Relationship Among Parties Affected by Agreement

The relationship between CHC and Participating Providers is that of independent contractors. Participating Providers are not agents or Employees of CHC, nor is CHC or any Employee of CHC 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 CHC, and neither shall be liable for any acts or omissions of CHC for the performance of services under this Agreement.

14.11 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.

14.12 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.

14.13 Valid Amendment

No change in this Agreement shall be valid unless approved by an officer of CHC, and evidenced by endorsement on this Agreement and/or by amendment to this Agreement. Such amendment will be incorporated into this Evidence of Coverage.

14.14 Waiver

The failure of CHC, 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.

COVENTRY HEALTH CARE OF IOWA, INC.
HMO Open Access Evidence of Coverage

Amendment

The Evidence of Coverage is hereby amended by replacing Section 2.6.1 with the following language:

2.6.1 Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an Employee and his or her Dependents may enroll in CHC if the Employee waived Coverage under CHC at the time Coverage was most recently made available because the Employee or Dependent had other coverage at the time Coverage under CHC was offered and the Employee's or Dependent's other coverage:

- Was COBRA continuation coverage that has since been exhausted; or,

- If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes (1) a loss of Coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or (2) in the case of coverage offered through an HMO, loss of coverage because the Employee or dependent no longer works or lives in the HMO's service area. This term does not include loss of Coverage due to failure to timely pay required contributions or premiums or loss of Coverage for cause (i.e., fraud or intentional misrepresentation); or

- A situation in which the Employee or Dependent incurs a claim that would meet or exceed a lifetime limit on all benefits offered under the other coverage.

Required Length of Special Enrollment**.** An Employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other Coverage was lost, or in the case where the Employee or Dependent has exceeded a lifetime limit on all benefits offered under the other coverage, no later than thirty-one (31) days from the date a claim is first denied due to the operation of a lifetime limit on all benefits.

Effective Date of Coverage**.** If the Employee or Dependent enrolls within the thirty-one (31) day period, Coverage under CHC will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for special enrollment is received.

The Evidence of Coverage is also amended by replacing Section 4.3 with the following language:

4.3 Certificates of Coverage. At the time Coverage terminates (or if your Coverage with Us includes a lifetime benefit maximum on all benefits, at the time the lifetime maximum is exceeded), 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.

Amendment to Open Access Evidence of Coverage

Form No. CHC-IA-Open Access EOC-07/04

COVENTRY
Health Care of Iowa, Inc.

PURPOSE OF AMENDMENT

This document is an attachment to Your Coventry Open Access Evidence of Coverage. The information explained in this Amendment modifies the terms of the Agreement under which You and any eligible Dependents 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 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. The Evidence of Coverage is hereby amended as set forth immediately below.

SECTION 1, USING YOUR BENEFITS, 1.4 Copayments, Coinsurance and Deductibles, page 10, *has been replaced with the following:*

You are responsible for paying Copayments to Participating Providers at the time of service. Coinsurance amounts, based on Our reimbursement to the Provider, will be billed to You at a later time by the Provider. Specific Copayments and Coinsurance amounts are listed in the Schedule of Benefits. You are responsible for paying Deductibles incurred in a Calendar Year. Coinsurance and Deductible amounts are not to exceed the Out-of-Pocket Maximum specified in the Schedule of Benefits.

When a Covered Individual incurs Covered charges in the last three (3) months of a Calendar Year which applies to the Covered Individual's Deductible for that year, such amounts are also applied to the Covered Individual's Deductible amount due for the following year.

***The following has been added under* SECTION 2, ENROLLMENT AND ELIGIBILITY, 2.4 Persons Not Eligible to Enroll, on page 14:**

2.4.4 A child born to or adopted by a Dependent child shall not be eligible to enroll.

The following element of* SECTION 5 COVERED SERVICES, 5.1 Table of Covered Services, on page 32*:

Reconstructive Surgery	Covered Service for repair of disfigurement for restoration of function resulting from an illness or injury that occurs while a Member is enrolled in the Health Plan.	Prior Authorization required. Cosmetic surgery is not Covered.

Has been replaced with the following:

Reconstructive Surgery	Covered Service for repair of disfigurement for restoration of function resulting from an illness or injury	Prior Authorization required. Cosmetic surgery is not Covered.

***The following Exclusion in* SECTION 6, EXCLUSION AND LIMITATIONS, page 36:**

6.1.9 Court-ordered services or services that are a condition of probation or parole.

Has been <u>replaced</u> with the following:

6.1.9 Court-ordered services (unless medically necessary) or services that are a condition of probation or parole.

The following Exclusion under* SECTION 6 EXCLUSIONS AND LIMITATIONS, Specifically Excluded services/items, unless covered in a rider or Your Schedule of Benefits, page 39, *has been <u>deleted</u>:

6.2.62 Self-inflicted (intentional) injury or sickness, suicide, or suicide attempt whether sane or insane;

***The following has been <u>added</u> under* SECTION 13, DEFINITIONS, page 67:**

13.60 "Custodial Care"
Care is considered custodial when it is primarily for the purpose of helping the Member with activities of daily living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to an individual who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized person, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include rest cures, respite care and home care which is or which could be provided by family members or private duty caregivers.

13.61 "High Tech 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 (MRI), intensity modulated radiation therapy (IMRT), magnetic resonance angiography (MRA) and positron emission tomography (PET).

***The following has been <u>added</u> under* SECTION 14, GENERAL PROVISIONS, page 69:**

14.15 Policies and Procedures
We may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.
14.16 Discretionary Authority
We have the discretionary authority to interpret the Subscriber's plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. We also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement.
14.17 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

Amendment to Open Access Evidence of Coverage

Form No. CHC-IA-Open Access EOC-07/04

COVENTRY
Health Care of Iowa, Inc.

PURPOSE OF AMENDMENT

This document is an attachment to Your Coventry Open Access Evidence of Coverage. The information explained in this Amendment modifies the terms of the Agreement under which You and any eligible Dependents 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 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. The Evidence of Coverage is hereby amended as set forth immediately below.

Modify each of the elements as defined below –

Replace **contact information, to include health plan address, reflected on page 3 and on page 56 of SECTION 10 INQUIRIES, COMPLAINTS AND GRIEVANCES 10.2 Procedure for Filing an Inquiry, Complaint, or Appeal to the following:**

Coventry Health Care of Iowa, Inc.
4320 114th Street
Urbandale, IA 50322
800-257-4692 or 515-225-1234

Addition **to SECTION 2, ENROLLMENT AND ELIGIBILITY, 2.6 Special Enrollment, at end of element 2.6.1 Special Enrollment Due to Loss of Other Coverage, page 15, and to end of first paragraph of element 2.6.2 Enrollment Due to New Dependent Eligibility, page 16, as follows:** If Your Employer Group offers more than one health plan, the event also allows each of You (You, Your Spouse, and/or each of Your eligible Dependent Children) to move from one Plan option to another.

Replacement **of SECTION 2, ENROLLMENT AND ELIGIBILITY, 2.6 Special Enrollment, 2.6.1 Special Enrollment Due to Loss of Other Coverage, Required Length of Special Enrollment, page 15, and 2.6.2 Enrollment Due to New Dependent Eligibility, Required Length of Special Enrollment, page 16, with the following:** Required Length of Special Enrollment. An Employee and his or her Dependents must request special enrollment, in writing, no later than thirty-one (31) days from the date of marriage, or sixty (60) days from the birth, legal adoption or legal placement for adoption.

Addition **of SECTION 2, ENROLLMENT AND ELIGIBILITY, 2.6 Special Enrollment, new element 2.6.3 to page 16 as follows: 2.6.3 Enrollment Due to New Dependent Resulting from Event.** The following events allow You to add only the new dependent resulting from the event:

- Dependent that resumes full-time student status, effective the first of the month following appropriate notification and verification.
- Addition of Child by Court Order, effective the date required by the order.

Replacement **of Section 3.2.2 of SECTION 3 EFFECTIVE DATES, page 17, with the following:** Dependents who are special enrollees can be covered under this Agreement when stated in Section 2.6 above; provided that a child born to a Subscriber will be covered for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first sixty (60) days from the date of birth upon receipt of the Enrollment Form. Applicable premiums must be paid for this Coverage. For Coverage to continue beyond the first sixty (60) days, an application to add the child as a Dependent must be received within sixty (60) days from the date of birth. Any newborn that is covered for the first sixty (60) days from the date of birth but is not eligible to enroll as a Dependent under this Agreement may convert to an individual contract under the terms and conditions set forth in Section 9 of this Agreement. Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order shall be Covered 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.

Addition **of new bullets to define termination events under SECTION 4, TERMINATION OF COVERAGE, 4.1 Termination of Coverage For Members, page 20, as follows:**

- Completion of full-time student schooling of dependent.
- Dependent Child who is not a full-time student or permanently disabled and who has reached the limiting age as defined in this Agreement or in the Group Contract.
- Marriage of a dependent child.
- Reaching of the Overall Lifetime Benefits Maximum.
- Divorce, Annulment, or Legal Separation of the Spouse.
- Death.

Replacement **of the Newborn children coverage paragraph under SECTION 5 COVERED SERVICES 5.1 Table of Covered Services, Maternity Services, page 28, with the following:** Newborn children are covered from the date of birth for a period of sixty (60) days upon receipt of the Enrollment Form. For Coverage to continue beyond the first sixty (60) days, the Enrollment Form to add the child as a Dependent must be received within sixty (60) days from the date of birth.

Replacement **of the Note under SECTION 6 EXCLUSIONS AND LIMITATIONS, 6.3 Exclusion of Coverage for Pre-existing Medical Conditions, page 41 with the following:**
Note: The Health Plan will not impose a Pre-existing Medical Condition exclusion period for pregnancy or on a newborn, a child under eighteen (18) years of age who is adopted or legally placed for adoption, provided the child is Covered under this Agreement within sixty (60) days of birth, adoption, or placement for adoption. However, if the child has a significant break in creditable Coverage of at least sixty-three (63) consecutive days, the Health Plan may impose a Pre-existing Medical Condition exclusion period on the child.

Delete **the following statement from SECTION 8, CONTINUATION OF COVERAGE, 8.1 Continuation Of Coverage for Certain Subscribers and Dependents, page 50:** You should also refer to Section 9 for any conversion privilege You may have at the end of any period of continuation Coverage.

Delete **the entire SECTION 9, CONVERSION, beginning on page 53,** as well as the table of contents reference to this section.

Change SECTION 7, COORDINATION WITH OTHER COVERAGE (COORDINATION OF BENEFITS-COB), beginning on page 44, as defined below –

Replace **7.2 Definitions, 7.2.1 "Plan" with the following:**

7.2.1 A "**Plan**" means a form of Coverage with which coordination is allowed, such as any of the following that provides benefits or services for medical treatment. Separate parts of a Plan that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one Plan and there is no COB among those separate parts of the Plan.

7.2.1.1 "**Plan**" includes: group and non-group insurance, closed panel or other forms of group or group-type or non-group Coverage (whether insured or uninsured), medical care components of long-term care contracts, medical benefits covered in automobile "no fault" or "traditional" contracts, and Medicare or any other governmental benefits as permitted by law and subject to the rules on COB with Medicare set forth below.

7.2.1.2 "**Plan**" does not include: accident only coverage, hospital indemnity insurance or other fixed indemnity Coverage, school accident-type Coverage, limited benefit health insurance Coverage, specified disease or accident coverage, long-term care policies for non-medical services, Medicare supplemental policies, Medicaid policies or Coverage under other governmental Plans, unless permitted by law.

7.2.1.3 Each contract for Coverage under Section 7.2.1.1 or 7.2.1.2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Replace **7.2 Definitions, 7.2.3 "Allowable Expense" with the following:**

7.2.3 **"Allowable Expense"** means a health care service or expense including deductibles, coinsurances, and co-payments, without reduction of any applicable deductible, that is Covered, at least in part by any of the Plans covering You or Your Covered Dependent. 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. The following are examples of expenses or services that are not Allowable Expenses:

7.2.3.1 If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is otherwise Covered) is not an Allowable Expense.

7.2.3.2 If a Member is Covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

7.2.3.3 If a Member is Covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

7.2.3.4 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 and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit for a specific negotiated fee or payment amount that is different from the Primary Plan's payment arrangement and if the providers' contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

7.2.3.5 The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions is not an Allowable Expense.

7.2.3.6 Expenses for dental care, vision care, prescription drug, and hearing aids are not Allowable Expenses.

7.2.3.7 If all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account pursuant to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.

7.2.3.8 Any expense or a portion of an expense that is not Covered by any of the plans is not an Allowable Expense.

7.2.3.9 Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered person is not an Allowable Expense.

Replace **the first sentence of 7.3.2 with the following:**

A Plan that does not contain a coordination of benefits provision that is consistent with the Iowa COB regulations is always Primary.

Replace **Order of Benefit Determination Rules**, **all elements of 7.3.4 with the following:**

7.3.4 The first of the following rules that describes which Plan pays its benefits before another plan is the rule to use.

7.3.4.1 **Non-Dependent or Dependent.** The Plan that covers the Member other than as a dependent, for example as an Employee, Member, policyholder, 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 (e.g. a retired employee) and Primary to the Plan covering the Member as other than a dependent 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.

7.3.4.2 **Child Covered Under More than One Plan.** Unless a court decree states otherwise, the order of benefits when a child is covered by more than one Plan is:

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 is earlier in the Calendar Year
- If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.

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 state that one of the parents is responsible for the 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. If that parent does not have health care coverage but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.
- If a court decree states both parents are responsible or awards joint custody without specifying that one party has the responsibility for the Dependent child's health care expenses or health care coverage, the provisions of 7.3.4.2.i shall determine the order of benefits.
- 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 is as follows:
  - The Plan of the Custodial Parent;
  - The Plan of the spouse of the Custodial Parent;
  - The Plan of the non-custodial parent; and then
  - The Plan of the spouse of the non-custodial parent.

iii. For a Dependent child covered under more than one plan by individuals who are not the parents of the child, the order of benefits shall be determined by 7.3.4.2.i and 7.3.4.2.ii above as if those individuals were parents of the child.

7.3.4.3 Active or inactive 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 or Dependent is the Secondary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7.3.4.4 COBRA or State Continuation Coverage. If a Member whose Coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the Member as an Employee, Member, Subscriber or retiree is Primary, and the continuation Coverage is Secondary. 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.

7.3.4.5 Longer or shorter length of Coverage. The Plan that Covered the Member for a longer period of time is the Primary Plan. Length of Coverage is measured from the person's first date of Coverage under the Plan.

7.3.4.6 If the preceding rules do not determine the Primary Plan the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, We will not pay more than we would have paid had We been Primary.

Replace **7.4 Effect On The Benefits of this Health Plan, with the following:**

7.4 Effect On The Benefits of this Health Plan.
When We are Secondary, we will calculate the benefits we would have paid on the claim in the absence of other Coverage and apply that calculated amount to any Allowable Expense under our Plan that is unpaid by the Primary Plan. We may reduce Our payment so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more that 100 percent of total Allowable Expenses for that claim. As Secondary, we shall apply towards the Deductible any amounts that would have been applied in the absence of other health care coverage with consideration to the following:

7.4.1 Under the terms of a Closed Panel Plan, benefits are not payable if the covered person does not use the services of a closed panel provider.

7.4.2 If Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall pay or provide benefits as primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals paid or provided by the Primary Plan.

7.4.3 If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

7.4.4 If covered by more than one Secondary Plan, the order of benefit determination rules decide the order in which Secondary Plan benefits are determined in relation to each other.

7.4.5 If plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the info needed to pay the claim, the plans shall immediately pay in equal shares, no greater than had they been primary, and will determine liabilities after payment.

Add **the following bullet to the end of section 7.6 Right to Receive and Release Needed Information,**

- File all claims with each Plan for You and Your Dependents if covered by more than one health benefit plan.

Replace **entire SECTION 12, RIGHT OF RECOVERY (THIRD PARTY LIABILITY SUBROGATION), page 59, with the following:**

SECTION 12, SUBROGATION AND REIMBURSEMENT,

The benefits payable hereunder as a result of any injuries which give rise to a claim by any participant, beneficiary or any other covered person, hereinafter individually and collectively "Participant", against a third party tortfeasor or against any person or entity as the result of the actions of a third party are excluded from coverage under this plan. This Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments (including auto) or medical expense type coverage to the extent of that coverage. However, this Plan will provide benefits, otherwise payable under this Plan, to or on behalf of said Participant only on the following terms and conditions:

12.1 In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Participant's (the term Participant includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. The Participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Participant shall do nothing after loss to prejudice such rights. The Participant hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.

12.2 The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

12.3 The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Participant or his/her representatives, and the Participant hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Participant agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Participant and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the participant.

12.4 By accepting benefits hereunder, the Participant hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Participant. This assignment is binding on any attorney who represents the Participant whether or not an agent of the Participant and on any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.

12.5 The subrogation and reimbursement rights and liens apply to any recoveries made by the Participant as a result of the injuries sustained, including but not limited to the following:

12.5.1 Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.

12.5.2 Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Participant or other person.

12.5.3 Any other payments from any source designed or intended to compensate a Participant for injuries sustained as the result of negligence or alleged negligence of a third party.

12.5.4 Any worker's compensation award or settlement.

12.5.5 Any recovery made pursuant to no-fault insurance.

12.5.6 Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

12.6 No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

12.7 No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

12.8 The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

12.9 No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".

12.10 The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

12.11 The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

12.12 In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

12.13 Any reference to state law in any other provision of this policy shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.