

SERFF Tracking Number: CMLX-125830219 State: Arkansas
 Filing Company: Companion Life Insurance Company State Tracking Number: 40352
 Company Tracking Number: GHSAR0003201F01
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: MMEM02GR08
 Project Name/Number: MMEM02GR08/GHSAR0003201F01

Filing at a Glance

Company: Companion Life Insurance Company

Product Name: MMEM02GR08

SERFF Tr Num: CMLX-125830219 State: ArkansasLH

TOI: H15G Group Health -

SERFF Status: Closed

State Tr Num: 40352

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.002 Large Group Only

Co Tr Num: GHSAR0003201F01

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI CompanionLife

Disposition Date: 09/29/2008

Date Submitted: 09/24/2008

Disposition Status: Approved-Closed

Implementation Date Requested: 09/24/2008

Implementation Date:

State Filing Description:

General Information

Project Name: MMEM02GR08

Status of Filing in Domicile: Pending

Project Number: GHSAR0003201F01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 09/29/2008

State Status Changed: 09/29/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Companion Life Insurance Company hereby re-files its Group High Deductible Health Plan. The forms are new and will not replace any forms that have been previously approved in your state. They will be used to market benefits in connection with hospital, surgical, anesthesia, out-patient physician office visits, outpatient diagnostic x-rays and laboratory, outpatient prescription drugs and other health care services to employer-employee groups through a network of independent licensed agents. The policy is divided into two sections, the employer section and the employee section.

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Both sections together form the policy and include all of the benefits available under the plan. In-network services will be provided by reputable PPO provider networks. The Group Insurance Health Statement that will be used with this product was previously approved by your Department on November 28, 2006.

The policy will not be used with a Health Savings Accounts (HSA); however, such language has been added in the event an HSA is a future consideration.

Company and Contact

Filing Contact Information

Ronnie Jackson, Compliance
 7909 Parklane Rd
 Columbia, SC 29223-5666

Ron.Jackson@companiongroup.com
 (803) 735-1251 [Phone]
 (800) 836-5433[FAX]

Filing Company Information

Companion Life Insurance Company
 7909 Parklane Rd, Suite 200
 Columbia, SC 29223-5666

CoCode: 77828 State of Domicile: South Carolina
 Group Code: 661 Company Type:
 Group Name: Companion Life State ID Number:
 Insurance Company
 FEIN Number: 57-0523959

(803) 735-1251 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Companion Life Insurance Company	\$50.00	09/24/2008	22687943

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/29/2008	09/29/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/26/2008	09/26/2008	SPI CompanionLife	09/26/2008	09/26/2008
Pending Industry Response	Rosalind Minor	09/24/2008	09/24/2008	SPI CompanionLife	09/26/2008	09/26/2008
Pending Industry Response	Rosalind Minor	09/24/2008	09/24/2008	SPI CompanionLife	09/26/2008	09/26/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection Response	Note To Reviewer	SPI CompanionLife	09/29/2008	09/29/2008

SERFF Tracking Number: CMLX-125830219 State: Arkansas
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Disposition

Disposition Date: 09/29/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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 Project Name/Number: MMEM02GR08/GHSAR0003201F01

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Readability Certificate	Approved-Closed	Yes
Supporting Document	Consumer Information Notice	Approved-Closed	Yes
Supporting Document	Compliance Certificate (PPO)	Approved-Closed	Yes
Supporting Document	GHDHP 1010 (08/08)	Approved-Closed	Yes
Supporting Document	Application for High Deductible Health Plan	Approved-Closed	Yes
Form	Group High Deductible Health Insurance Policy	Approved-Closed	Yes
Form	Application for High Deductible Health Plan	Approved-Closed	Yes
Form	High Deductible Health Plan Enrollment Form	Approved-Closed	Yes

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Project Name/Number: MMEM02GR08/GHSAR0003201F01

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/26/2008
Submitted Date 09/26/2008

Respond By Date

Dear Ronnie Jackson,

This will acknowledge receipt of the captioned filing.

Objection 1

- GHDHP 1010 (08/08) (Supporting Document)

Comment: Thank you for the corrections to the filing. There are still some areas on the schedule of benefits that is not in compliance with our Bulletin 9-85. For example: Treatment of ASD, allergy injections and chiropractic services is paid at 100% after the co-payment and 65% for non-PPO. This is more than a 25% differential.

Also, some of the benefits are paid at 100% or 90% for PPO and no coverage for a non-PPO. This also is not in compliance.

On filings from other companies, they respond so the new form is on the Form tab. From my side I see the old form in gray and the new form is above the old one. Could you please do this with the corrected form and not attach them under supporting documents?

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/26/2008
Submitted Date 09/26/2008

Dear Rosalind Minor,

Comments:

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Project Name/Number: MMEM02GR08/GHSAR0003201F01

This is in response to the additional areas of concern regarding the schedule of benefits.

Response 1

Comments: I have gone through the schedule of benefits and have corrected the 25% benefit levels and non-coverage benefits for Non-PPO providers.

Related Objection 1

Applies To:

- GHDHP 1010 (08/08) (Supporting Document)

Comment:

Thank you for the corrections to the filing. There are still some areas on the schedule of benefits that is not in compliance with our Bulletin 9-85. For example: Treatment of ASD, allergy injections and chiropractic services is paid at 100% after the co-payment and 65% for non-PPO. This is more than a 25% differential.

Also, some of the benefits are paid at 100% or 90% for PPO and no coverage for a non-PPO. This also is not in compliance.

On filings from other companies, they respond so the new form is on the Form tab. From my side I see the old form in gray and the new form is above the old one. Could you please do this with the corrected form and not attach them under supporting documents?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I have attached the new form to the Form tab as requested. Please let me know if there any other areas of concern.

Sincerely,
SPI CompanionLife

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Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/24/2008
Submitted Date 09/24/2008
Respond By Date
Dear Ronnie Jackson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group High Deductible Health Insurance Policy (Form)

Comment: Under the schedule of benefits, the benefits payable a PPO and Non-PPO is are not in compliance with our Bulletin 9-85(2) which states the the difference in benefit levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. the Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Objection 2

- Group High Deductible Health Insurance Policy (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 3

- Group High Deductible Health Insurance Policy (Form)

Comment: Under the eligibility criteria for Conversion, it is stated that the insured must be continuously covered for three months. This is a limitation that is not in compliance with ACA 23-86-115.

Objection 4

- Group High Deductible Health Insurance Policy (Form)

Comment: The benefits for prescription medication does not comply with ACA 23-79-149(d) which states that insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network.

We will allow a co-pay of three (3) times that of a retail pharmacy. For example, if the copay for a participating pharmacy is \$10, we will accept a \$30 copay for a mail order pharmacy.

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Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Objection 5

- Group High Deductible Health Insurance Policy (Form)

Comment: Under the schedule of benefits, the benefits for well-child care is not in compliance with ACA 23-79-141. Immunizations must be paid at 100% for PPO and Non-PPO providers.

Objection 6

- Application for High Deductible Health Plan (Form)

Comment: The application must contain a Fraud Statement as outline under ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/26/2008
Submitted Date	09/26/2008

Dear Rosalind Minor,

Comments:

The policy and application have been revised per your instruction.

Response 1

Comments: The co-payments throughout the schedule page have been revised so that the benefit levels do not exceed 25%.

Related Objection 1

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

Under the schedule of benefits, the benefits payable a PPO and Non-PPO is are not in compliance with our Bulletin 9-85(2) which states the the difference in benefit levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. the Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

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Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: We have removed the time limit for furnishing proof of incapacity. Please see page C-39.

Related Objection 1

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: We have removed the "continuously covered for three months" language from the provision. See page C-72.

Related Objection 1

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

Under the eligibility criteria for Conversion, it is stated that the insured must be continuously covered for three months. This is a limitation that is not in compliance with ACA 23-86-115.

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Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: Pursuant to ACA 23-79-149(d), the limit set for the quantity of drugs has been revised so that such limit is applied uniformly. See Page C-20.

Related Objection 1

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

The benefits for prescription medication does not comply with ACA 23-79-149(d) which states that insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network.

We will allow a co-pay of three (3) times that of a retail pharmacy. For example, if the copay for a participating pharmacy is \$10, we will accept a \$30 copay for a mail order pharmacy.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: Immunizations are now paid at 100% for PPO and Non-PPO providers. See Page C-19.

Related Objection 1

SERFF Tracking Number: CMLX-125830219 State: Arkansas
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TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

Under the schedule of benefits, the benefits for well-child care is not in compliance with ACA 23-79-141. Immunizations must be paid at 100% for PPO and Non-PPO providers.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments: We have added a Fraud Statement at the end of page three.

Related Objection 1

Applies To:

- Application for High Deductible Health Plan (Form)

Comment:

The application must contain a Fraud Statement as outline under ACA 23-66-503 and Bulletin 7-97.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

The revised policy and application have been attached with our objection response to your continuation provision objection.

If there is anything else that you need, please let me know.

SERFF Tracking Number: CMLX-125830219 *State:* Arkansas
Filing Company: Companion Life Insurance Company *State Tracking Number:* 40352
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Product Name: MMEM02GR08
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Sincerely,
SPI CompanionLife

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/24/2008
Submitted Date 09/24/2008
Respond By Date
Dear Ronnie Jackson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group High Deductible Health Insurance Policy (Form)

Comment: The continuation provision in the policy is not in compliance with ACA 23-86-114(c)(1) which states that Continuation of coverage shall be available only to individuals who have been insured continuously under the group policy during the THREE-MONTH PERIOD prior to the termination of employment, membership or change in marital status. Also, coverage must be for at least 120 days.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/26/2008
Submitted Date 09/26/2008

Dear Rosalind Minor,

Comments:

Ms. Minor,

This is in response to your objection regarding the continuation provision.

Response 1

Comments: The continuation provision on page C-68 has been revised pursuant to ACA 23-86-114(c)(1).

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Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Related Objection 1

Applies To:

- Group High Deductible Health Insurance Policy (Form)

Comment:

The continuation provision in the policy is not in compliance with ACA 23-86-114(c)(1) which states that Continuation of coverage shall be available only to individuals who have been insured continuously under the group policy during the THREE-MONTH PERIOD prior to the termination of employment, membership or change in marital status. Also, coverage must be for at least 120 days.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: We have revised the policy and application (please see attached).

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: GHDHP 1010 (08/08)

Comment:

Satisfied -Name: Application for High Deductible Health Plan

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If there is anything else that you need, please let me know.

Sincerely,

SPI CompanionLife

SERFF Tracking Number: CMLX-125830219 State: Arkansas
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Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Note To Reviewer

Created By:

SPI CompanionLife on 09/29/2008 10:54 AM

Subject:

Objection Response

Comments:

Attached is the revised schedule page. Benefits paid at 100% (in-network) have been corrected by showing 75% (out-of-network). Also, those benefits that were paid at 100% or 90%, yet had no coverage for non-PPO providers, have been revised by adding coverage as required by Arkansas law. Thanks for your help (and patience) with the problem I had attaching the revised form to the "Forms Tab." Although I could not get it to work this time, I assure you that in the future this will be done correctly. Again, THANK YOU!

[SCHEDULE OF BENEFITS]

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-753-0404 to find out if your Provider is a Participating Provider.

General Provisions	
When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Covered Persons subject to the terms of this Plan of Benefits. When a Benefit has a “Non-Covered” notation associated with it, the Benefit is not available to the Covered Person. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.	
Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following [60] days of employment.
Minimum hours per week:	At least [30] hours per week.
Minimum weeks per year:	At least [48] weeks per year.
The column to the right identifies other group classifications, as defined by the Employer, that may participate in this Plan of Benefits:	<ul style="list-style-type: none"> •Contracted Workers •Appointed/Elected Officials •Board Members •Partners •Major Stockholders •Retirees
Benefit Year Deductible:	<p>[\$5,000] per Covered Person per Benefit Year, at a Participating Provider, limited to 3 per family.</p> <p>[\$7,500] per Covered Person per Benefit Year, at a Non-Participating Provider, limited to 3 per family.</p> <p>Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.</p>
Annual Out-of-Pocket Maximum:	<p>[\$5,000] per Covered Person, and [\$7,500] per family at a Participating Provider.</p> <p>[\$7,500] per Covered Person, and [\$10,000] per family at a Non-Participating Provider.</p> <p>Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.</p> <p>Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.</p> <p>The Coinsurance for Mental Health Services and Substance Abuse Services does not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits. If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will not accumulate toward the Out-of-Pocket Maximum.</p>

SCHEDULE OF BENEFITS

General Provisions (Continued)

Lifetime Maximum: \$2,000,000 per Covered Person.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is \$100 for a Participating Provider and \$200 for a Non-Participating Provider.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The initial Benefit Year is [01/1/08 through 12/31/08]. The Anniversary Date is [01/01].

Covered Expenses incurred during the last three (3) months of a Benefit Year, which are applied toward satisfying that year's Benefit Year Deductible will be carried over and applied toward satisfying the next year's Benefit Year Deductible.

Provided that there was no lapse in insurance coverage between the prior Plan and this Plan of Benefits, Covered Expenses incurred by a Covered Person during the last four (4) months of the Employer's previous Plan which were applied toward satisfying any deductible, Out-of-Pocket Maximum and Lifetime Maximum under that Plan, will be carried over and applied toward satisfying the initial Benefit Year Deductible, Out-of-Pocket Maximum or Lifetime Maximum.

In the event that two or more Covered Persons of one family incur charges for Covered Expenses as a result of injuries received in the same accident, only one Benefit Year Deductible will be applied to Covered Expenses that are incurred by all such Covered Persons as a result of injuries sustained in that same accident.

All Admissions require Pre-Certification. If Pre-Certification is not obtained, room and board charges will be denied. Other services may also require Pre-Certification. Please see the Schedule of Benefits and Plan of Benefits for more information.

Pre-Certification is required for the following outpatient Benefits:

MRI

MRA

CT Scans

PET Scans

Nuclear Cardiology Exam

Sclerotherapy

Septoplasty

Any surgical procedure that may be potentially cosmetic: i.e. blepharoplasty, reduction mammoplasty

Hysterectomy

Investigational procedures

Benefits for MRIs, MRAs, CT Scans, PET Scans and Nuclear Cardiology exams will be denied with Pre-Certification is not obtained or approved by the Companion Life. Benefits for any other outpatient services that require Pre-Certification will be reduced by 50% of the Allowable Charge when Pre-Certification is not obtained or approved by the Companion Life.

The coverage for Members may terminate on any given day during the term of this Plan of Benefits.

SCHEDULE OF BENEFITS

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital charges for room and board related to Admissions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient physical rehabilitation services (limited to a lifetime maximum payment of \$100,000) when Pre-Certified by the Companion Life and performed at a Provider designated by the Companion Life	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Skilled Nursing Facility Admissions (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Long Term Acute Care Hospital (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 75% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services performed at an independent laboratory facility	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 75% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
True Emergency Room Visits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Non-true Emergency Room Visits (Copayment waived if admitted)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$50 Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$100 Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other covered outpatient Benefits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Physician Services in a Hospital	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Physician services for lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 75% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Services in the Physician's office (other than Mental Health Services, Mental Health Conditions, Maternity Care, Substance Abuse Services, physical therapy, dialysis treatment and second surgical opinion)	<p>The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.</p>	<p>The Company pays 75% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services in the Covered Person's home	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Second surgical opinion	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Physician Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

**MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND
SUBSTANCE ABUSE SERVICES**

Mental Health and Substance Abuse Services are limited to a combined total of thirty (30) days of inpatient care (Admission) or twenty (20) outpatient appointments per Covered Person per Benefit Year. This combined total does not apply to Mental Health Conditions. As with all other Benefits, Covered Expenses included in this section apply to the Lifetime Maximum. Additionally, there is a \$10,000 lifetime maximum payment for Substance Abuse Services for each Covered Person. Pre-Certification is required for Mental Health Services, Mental Health Conditions and Substance Abuse Services. If Pre-Certification is not obtained or approved by the Companion Life, the following penalties will apply.

**Inpatient: Denial of room and board
Outpatient: 50% of the Allowable Charge
Office: 50% of the Allowable Charge**

	Participating Provider	Non-Participating Provider
Inpatient Hospital charges for Mental Health Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person must pay the balance of the Provider's charge
Inpatient Hospital charges for Mental Health Conditions	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person must pay the balance of the Provider's charge
Inpatient Hospital charges for Substance Abuse Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person must pay the balance of the Provider's charge

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient Hospital or clinic charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Substance Abuse Services and for the treatment of Alcohol Abuse	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Medically necessary services for the treatment of autism spectrum disorders (ASD) when the criteria of the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR) are met	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 75% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Inpatient Physician charges for Substance Abuse Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient or Office Physician charges for Mental Health Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient Physician charges for Mental Health Conditions	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Office Physician charges for Mental Health Conditions	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 75% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient or Office Physician charges for Substance Abuse Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES		
	Participating Provider	Non-Participating Provider
Ambulance service: Ground transport to and from a Hospital in an ambulance (benefit includes air ambulance)	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is \$500 or more, Pre-Certification is required)	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services.	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Medical Supplies	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Home Health Care, including private duty nursing services (Pre-Certification is required)	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Maternity	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Hospice Care (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Provider Charges for physical therapy and occupational therapy (Limited to a \$1,000 combined maximum Benefit per Covered Person per Benefit Year. Please see the "Outpatient Rehabilitation" section in Section IV for further limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Speech therapy (Please "Outpatient Rehabilitation" in Section IV for limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
<p>Radiation therapy</p> <p>Cancer chemotherapy</p> <p>Respiratory therapy</p> <p>Pre-certification is required</p>	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy.	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider’s charge
In Vitro Fertilization	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider’s charge
Human organ and tissue transplant services (excluding drugs), limited to a \$250,000 maximum payment per Covered Person per lifetime and with the following individual organ transplant limits: Bone Marrow/Stem Cell \$250,000 Cornea \$ 25,000 Heart \$120,000 Heart/Lung \$130,000 Heart/Lung (double) \$250,000 Kidney \$ 60,000 Kidney (double) \$120,000 Lung (double) \$250,000 Lung/Segmental Lung \$130,000 Liver/Segmental Liver \$225,000 Pancreas \$ 80,000 Pancreas and Kidney \$ 80,000 Human organ and tissue transplant services are only covered if provided at a transplant center approved by the Company in writing Physician Charges are subject to the Benefit Year Deductible.	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible and Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person must pay the balance of the Provider’s charge

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Allergy Injections	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 75% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Acupuncture	Non-Covered	Non-Covered
Chiropractic Services, including related x-rays, modalities and office visits, limited to a \$500 maximum payment and 20 visits per Covered Person per Benefit Year	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 75% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Cosmetic Services	Non-Covered	Non-Covered
Disease Management Program	Covered	Non-Covered
Health Questions Hotline	Covered	Non-Covered
Hearing Aids	Non-Covered	Non-Covered
Oxygen (Pre-Certification is required)	Covered	Covered
Impacted tooth removal	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Impotence treatment	Non-Covered	Non-Covered
Online Health Assessment Program	Covered	Non-Covered
Massage Therapy	Non-Covered	Non-Covered
Maternity Management Program	Covered	Non-Covered
Tobacco Cessation Program	Covered	Non-Covered

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Speech or Hearing Impairment	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Temporomandibular Joint Disorder (TMJ) including treatment, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Orthognathic surgery, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Phenylketonuria (PKU) Formula	Covered	Covered
Weight Control Program	Covered	Non-Covered
Supplemental Accident benefits (the first \$300 incurred per Benefit Year is payable at 100% and is not subject to the Benefit Year Deductible)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

ANNUAL BENEFITS The Benefit Year Deductible does not apply to these Benefits.		
	Participating Provider	Non-Participating Provider
Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	The Company pays 75% of Allowable Charge
Physical exam (limited to \$250 per Covered Person per Benefit Year for Covered Persons 40 or older)	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	The Company pays 75% of the Allowable Charge after the Covered Person pays the \$60 Copayment
Prostate examination, screenings, and laboratory work (limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	The Company pays 75% of Allowable Charge
Colorectal Cancer Screenings (limited to: <ul style="list-style-type: none"> • One (1) fecal occult blood testing of three consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy once every five years • One (1) double contract barium enema every five years • One (1) colonoscopy every ten years) 	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	The Company pays 75% of the Allowable Charge after the Covered Person pays the \$60 Copayment
Well child care performed in the Physician's office and immunizations for Dependents up to age 6	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$60 Copayment
Gynecological exam (limited to two (2) per Benefit Year) The \$250 per Covered Person per Benefit Year physical exam maximum will apply. Once this maximum is met the contract Benefit Year Deductible and Coinsurance will apply.	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	The Company pays 75% of the Allowable Charge after the Covered Person pays the \$60 Copayment
Mammography screenings: <ul style="list-style-type: none"> • One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. • A mammogram once every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician. • A mammogram every year for any woman who is fifty (50) years of age or older. <p style="margin-left: 20px;">Such coverage shall not exceed the cost of the examination.</p>	The Company pays 100% of Allowable Charge	The Company pays 75% of Allowable Charge

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Generic Drugs	The Covered Person pays a \$20 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$10 Copayment after meeting the Covered Member's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$10 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Preferred Brand Drug	The Covered Person pays a \$55 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$25 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$25 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Non-Preferred Brand Drug	The Covered Person pays a \$95 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$40 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$40 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Contraceptives (Prescription Drugs)	Covered	Covered	Covered
Prescription Drugs used for smoking cessation	Covered	Covered	Covered
Prescription Drug Deductible*	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year

PRESCRIPTION DRUG BENEFIT (CONTINUED)			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Maximum Prescription Drug Benefit	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)
Prescription Drugs used for obesity/weight control	Non-Covered	Non-Covered	Non-Covered
Diabetic syringes and supplies	Covered	Covered	Covered

*The Prescription Drug deductible is integrated in the Benefit Year Deductible. Once the Benefit Year Deductible is satisfied the Prescription Drug deductible is satisfied, and the Covered Person is only responsible for remaining Copayment.]

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Form Schedule

Lead Form Number: GHDHP 1010 (08/08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GHDHP 1010 (08/08)	Policy/Cont ract/Fraternal Insurance Certificate	Group High Deductible Health Insurance Policy	Initial		42	GHDHP 1010 (08_08).PDF
Approved-Closed	GHDHA 1020	Application/ Enrollment Form	Application for High Deductible Health Plan	Initial		0	GHDHA 1020.PDF
Approved-Closed	GHDHE 1030	Application/ Enrollment Form	High Deductible Health Plan Enrollment Form	Initial		0	GHDHE 1030.PDF



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
PO Box 100102, Columbia, SC 29202-3102
(803) 735-1251 (herein called "Companion Life")

hereby issues GROUP POLICY NUMBER: [xxxxxxx] (herein called "this Policy")
with POLICY EFFECTIVE DATE: [Month Day, Year]
to the POLICYHOLDER: [ABC Company]
(herein called "the Employer")
in STATE OF DELIVERY: [State]
on POLICY ISSUE DATE: [Month Day, Year];

and agrees to pay the benefits described in this Policy, subject to its terms and conditions, with respect to Insured Persons as defined herein.

This Policy is issued to the Employer named above in consideration of, and reliance upon, the statements made in the attached Application and timely premium payment as stated in this Policy.

The first premium is due and payable on or before the Policy Effective Date shown above. Subsequent premiums are due and payable as stated in the Premiums section of this Policy.

This Policy takes effect at 12:01 AM at the Employer's business address shown on the attached Application on the Policy Effective Date shown above. It continues in effect until the date it is canceled or terminated as provided in the Cancellation, Termination and Renewal section of this Policy, unless it is renewed (at the sole option of Companion Life) in accordance with the provisions of that section.

This Policy is governed by the laws of the State of Delivery shown above. If a policy conflicts with the state laws of Arkansas the provision will be administered according to the law.

Signed for Companion Life Insurance Company at Columbia, South Carolina on the Policy Issue Date shown above by:

A handwritten signature in black ink, appearing to read 'Trescott N. Hinton, Jr.' with a stylized flourish at the end.

Trescott N. Hinton, Jr.
President

**GROUP HIGH DEDUCTIBLE
HEALTH INSURANCE POLICY**

INTRODUCTION

This policy is divided into two sections:

- the employer section
- the employee section

Both sections together form the policy and include all of the benefits available under a plan.

Premiums

A. Premium Payment

[Base] Premiums are due and payable on the [XXth] day of each month[, and Claims-Based Premiums are due on the date of written notice of such premiums by Companion Life to the Employer]. Payment of the appropriate premium constitutes an acceptance of the premium rate.

B. Determination of the Premium

The premium for this Policy will be determined on the basis of the rates indicated on the Schedule of Premium Rates section of this Policy, subject to the right of Companion Life to revise the rates on any of the following dates (after the first twelve (12) months this Policy is in effect):

1. any premium due date. Companion Life will notify the Employer at least forty-five (45) days in advance of the Effective Date of said revision;
2. on any Effective Date of a change in the terms of this Policy

If a revision is made to the rates for this Policy, the revised rates will be the basis for future premiums, until subsequently revised.

C. Change in Coverage

1. If coverage under this Policy is changed due to a change in the terms of the Policy, any premium charge or credit will be computed as of the Effective Date of the change.
2. The following provision is applicable if the increase, decrease, addition or termination, respectively, is not due to a change in the terms of the Policy.

If coverage is decreased or terminated after the first day of any billing month that this Policy remains in force, premiums relating to the decrease or termination will cease at the end of the billing month in which the decrease or termination is effective.

If coverage is increased or added after the first day of any billing month that this Policy remains in force, premiums relating to the increase or addition will begin on the first day of next billing month following the date the increase or addition is effective.

D. Clerical Error

If it is determined that premiums are due Companion Life, or that a premium refund is due as a result of a clerical error, all such premiums or refunds will be calculated at the appropriate premium for the period involved and will be limited to a maximum of twelve (12) months.

Premiums (Continued)

E. Grace Period

The Employer is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy continues in force, unless the Employer has given Companion Life written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The Employer shall continue to be liable to Companion Life for the payment of a pro ratio premium for the time the policy was in force during the grace period. If Companion Life agrees to continue this Policy beyond the end of the grace period, payment of any premium is payable to Companion Life for the time coverage under this Policy is continued in force.

General Provisions

1. Right to Amend

Companion Life may from time-to-time amend this Policy and the certificates issued hereunder. The change or amendments will not be effective until after thirty-one (31) days written notice to the Employer; however, increases in benefits provided or decreases in the premiums for this Policy may be made effective without notice. Notice of an amendment will be effective to the Employer or to an Employee when addressed to the Employer's office as shown in the Application to this Policy. Companion Life has no responsibility to provide individual notice to each Employee that an amendment to this Policy has been made.

2. Entire Contract

The entire contract is made up of: (a) the Policy; (b) the application for coverage under the Policy; and (c) any subsequent amendment, rider or endorsement to the Policy. A copy of the policyholder's application must be attached to the policy when issued. All statements made by the policyholder or by the persons insured are considered representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

No agent, except Our President, Vice President, Secretary or Assistant Secretary, can extend the time for payment of any premium. A change to the Policy which requires the Policyholder's consent will be valid only if signed by the Policyholder and Our President, Vice President, Secretary or Assistant Secretary. A change to a Policy which requires Your consent will be valid only if signed by You and Our President, Vice President, Secretary or Assistant Secretary.

Except as specifically provided herein, this Policy shall not make Companion Life liable or responsible for any duty or obligation which is imposed on the Employer by Federal or State law or regulations. To the extent that this Policy may be a welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Employer shall be the administrator of the welfare benefit plan and shall be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the welfare benefit plan, except those specifically undertaken by Companion Life herein.

General Provisions (Continued)

3. Time Limit on Certain Defenses

The validity of the policy may not be contested after it has been in force for two years from its date of issue. No statement, except fraudulent misstatements, made by any Insured Person covered under the policy relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the Insured Person's lifetime unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

4. Claim for Payment of Benefits

- a. An Insured Person must present an identification card when applying for Covered Expenses under this Policy.
- b. Written notice of care on which a Claim is based must be furnished to Companion Life, at its address shown on the face of the Policy, within twenty (20) days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, Companion Life will furnish or cause to be furnished to the Insured Person a Claim form. If the Claim form is not furnished within 15 days after the receipt of the notice by Companion Life, the Insured Person will be deemed to have complied with the requirements of this Policy as to proof of loss, if the Insured Person submits written proof covering the character and extent of the loss within the policy time fixed for filing proof of loss.
- c. An Insured Person must complete or cause to be completed a Claim, on forms prescribed by Companion Life, and will file it or cause it to be filed, along with all documentation required by Companion Life.
- d. The Claim must be received by Companion Life within ninety (90) days after the beginning of care; however, failure to file the Claim within the ninety (90) day period will not prevent payment of benefits if the Insured Person shows that it was not reasonably possible to timely file the Claim, provided the Claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, later than 12 months following the date proof of loss is otherwise required.
- e. The Claim will be deemed written proof of loss and written authorization from the Insured Person to Companion Life to obtain any medical or financial records and documents useful to Companion Life; however, Companion Life is not required to obtain any additional records or documents to support payment of a Claim and is responsible to pay Claims only on the basis of the information supplied to it at the time the Claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured Person's Claim will be deemed to be acting as the agent of the Insured Person.

General Provisions (Continued)

5. Payment of Claims

Companion Life will pay all benefits directly to the Employee upon receipt of due proof of loss. However, if an Insured Person provides Companion Life with a valid assignment form, Companion Life will pay all or any part of the benefits directly to the Provider. Any such payment made by Companion Life in good faith shall fully discharge the Company's liability to the extent of the payment. Companion Life will also pay benefits as described in Section IV of this Policy directly to a Provider if Companion Life has a written agreement with the Provider that provides for direct payment of benefits.

Benefits will be paid, with or without an assignment from an Insured Person, to public hospitals or clinics for services and supplies provided to the Insured Person if a proper claim is submitted by the public hospital or clinic. No benefits will be paid to the public hospital or clinic if such benefits have been paid to the Insured Person prior to receipt of the claim by Companion Life. Payment to the public hospital or clinic of benefits will discharge Companion Life from all liability to the Insured Person to the extent of the benefits so paid. Nothing in this section will be construed to require payment of benefits for the same services or supplies to both the Insured Person and the public hospital or clinic.

If this Policy is an integral part of an employee welfare benefit plan subject to the provision of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Companion Life is a claim fiduciary. As claim fiduciary, Companion Life shall have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by this Policy. Any judicial review of a decision of Companion Life shall be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

6. Time Payment of Claim

Payments for a covered claim will be paid within thirty (30) days after receipt of due written proof of loss; or the Participant, the Participant's assignee, health care professional, or health care facility will be notified that additional documentation is needed. All other benefits will be paid as soon as the required proof of loss is received.

7. Information and Records

Companion Life is entitled to obtain such authorization for medical and Hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification that the care and treatment received by the Insured Person was Medically Necessary, provided, however, that Companion Life will in every case hold such records as confidential except as authorized by an Insured Person.

General Provisions (Continued)

8. Review of Claims Denied In Whole or In Part

An Insured Person has sixty (60) days, from the date of receipt of notification of Companion Life's action on his or her Claim, to request a review of any benefits denied in whole or in part.

To request a review, the Insured Person must write to Companion Life stating the issue to be reviewed and attach to the request for review pertinent medical records or other information that the Insured Person offers in support of his or her Claim; the Insured Person may also request a description of any pertinent records that Companion Life relied on in making its original decision to deny the Claim in whole or in part.

A disposition of the Claim will not be deemed final until the time Companion Life renders its written decision. The written decision will be rendered within sixty (60) days after the request for review is received unless medical records are requested, in which case the decision will be rendered no later than one hundred twenty (120) days after the request for review is received. When a request for review is made later than sixty (60) days after notification of Companion Life's action, the foregoing time limitations shall not apply, but the review shall be made promptly while giving priority to requests made within sixty (60) days. Companion Life will send the Insured Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Policy provisions.

9. Legal Actions

No action at law or in equity will be brought to recover on this Policy until an Insured Person has exhausted the review procedure set forth in paragraph 6 above, nor will such action be brought after the expiration of five (5) years after the date written proof of loss is required to be furnished.

10. Identification Cards and Certificates

Companion Life will issue to the Employer for delivery to each Employee covered hereunder an identification card and an individual certificate summarizing the benefits to which the Employee is entitled. If any amendment to this Policy shall materially affect any benefits described in the certificate, new certificates or endorsements describing the changes will be issued.

11. Physical Examination

Companion Life at its own expense will have the right and opportunity to examine the Insured Person whose Injury or Illness is the basis of Claim, when and as often as it may reasonably require, during the pendency of a Claim or action hereunder.

12. Worker's Compensation

This Policy is not in lieu of and does not affect any requirements for coverage for Workers' Compensation Insurance.

General Provisions (Continued)

12. Conformity of State Statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is issued is amended to conform to the minimum requirements of such State.

13. Right of Reimbursement

If any payment under this Policy is made to or on behalf of a Covered Plan Participant on account of any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, the Employer and/or this Policy shall have a right to be reimbursed by the Covered Plan Participant (out of any settlement or judgments recovered which include payments for medical expenses) one dollar (\$1.00) for each dollar paid under the terms of this Group Health Plan Description without reduction for attorney's fees or costs incurred by the Covered Plan Participant in obtaining such settlements or judgments.

The Employer's and/or this Policy's right of reimbursement shall be in addition to any subrogation right or claim available to the Employer, and the Covered Plan Participant shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by Companion Life, on behalf of the Employer and/or this Policy, to exercise the Employer's and/or this Policy's right of reimbursement hereunder. No waiver, release of liability, or other documents executed by the Covered Plan Participant, without notice to and written consent of Companion Life, acting on behalf of the Employer, shall be binding upon the Employer.

14. Choice of Provider

You shall have the sole right to select Your own Physician and medical facilities. The Physician-patient relationship shall be maintained. However, Covered Charges and payment of benefits shall be as provided under the terms of the Policy.



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
PO Box 100102, Columbia, SC 29202-3102
(803) 735-1251 (herein called "Companion Life")

Companion Life Insurance Company, herein called the Company, hereby certifies that it has issued and delivered to the Policyholder a group health plan. The group Policy covers certain Covered Persons as described in the Policy.

This Certificate describes the benefits and provisions of the Policy. This Certificate becomes effective only if: (1) the Insured is eligible for insurance; (2) We have received the Insured's application/enrollment form; (3) the required premium has been paid; and (4) the Insured becomes insured in accordance with all of the provisions of the Policy.

No agent may change the Policy or waive its provisions.

This Certificate takes the place of any other certificate previously issued to the Insured under the Policy. It should be kept in a safe place.

Carefully read this Certificate including all provisions, benefits and limitations as soon as you receive it. It is important that you understand and are satisfied with the coverage provided under this Certificate.

IN WITNESS WHEREOF Companion Life Insurance Company caused this Certificate to be executed on the Date of Issue to take effect on the Certificate Effective Date.

For service or complaints about the policy, please address any inquiries to the address shown above or call [1-800-753-0404].

A handwritten signature in black ink, appearing to read 'Trescott N. Hinton, Jr.', written in a cursive style.

Trescott N. Hinton, Jr.
President

**GROUP HIGH DEDUCTIBLE HEALTH INSURANCE
CERTIFICATE OF COVERAGE**

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[SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-753-0404 to find out if your Provider is a Participating Provider.

General Provisions	
When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Covered Persons subject to the terms of this Plan of Benefits. When a Benefit has a “Non-Covered” notation associated with it, the Benefit is not available to the Covered Person. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.	
Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following [60] days of employment.
Minimum hours per week:	At least [30] hours per week.
Minimum weeks per year:	At least [48] weeks per year.
The column to the right identifies other group classifications, as defined by the Employer, that may participate in this Plan of Benefits:	<ul style="list-style-type: none"> •Contracted Workers •Appointed/Elected Officials •Board Members •Partners •Major Stockholders •Retirees
Benefit Year Deductible:	<p>[\$5,000] per Covered Person per Benefit Year, at a Participating Provider, limited to 3 per family.</p> <p>[\$7,500] per Covered Person per Benefit Year, at a Non-Participating Provider, limited to 3 per family.</p> <p>Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.</p>
Annual Out-of-Pocket Maximum:	<p>[\$5,000] per Covered Person, and [\$7,500] per family at a Participating Provider.</p> <p>[\$7,500] per Covered Person, and [\$10,000] per family at a Non-Participating Provider.</p> <p>Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.</p> <p>Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.</p> <p>The Coinsurance for Mental Health Services and Substance Abuse Services does not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits. If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will not accumulate toward the Out-of-Pocket Maximum.</p>

SCHEDULE OF BENEFITS

General Provisions (Continued)

Lifetime Maximum: \$2,000,000 per Covered Person.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is \$100 for a Participating Provider and \$200 for a Non-Participating Provider.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The initial Benefit Year is [01/1/08 through 12/31/08]. The Anniversary Date is [01/01].

Covered Expenses incurred during the last three (3) months of a Benefit Year, which are applied toward satisfying that year's Benefit Year Deductible will be carried over and applied toward satisfying the next year's Benefit Year Deductible.

Provided that there was no lapse in insurance coverage between the prior Plan and this Plan of Benefits, Covered Expenses incurred by a Covered Person during the last four (4) months of the Employer's previous Plan which were applied toward satisfying any deductible, Out-of-Pocket Maximum and Lifetime Maximum under that Plan, will be carried over and applied toward satisfying the initial Benefit Year Deductible, Out-of-Pocket Maximum or Lifetime Maximum.

In the event that two or more Covered Persons of one family incur charges for Covered Expenses as a result of injuries received in the same accident, only one Benefit Year Deductible will be applied to Covered Expenses that are incurred by all such Covered Persons as a result of injuries sustained in that same accident.

All Admissions require Pre-Certification. If Pre-Certification is not obtained, room and board charges will be denied. Other services may also require Pre-Certification. Please see the Schedule of Benefits and Plan of Benefits for more information.

Pre-Certification is required for the following outpatient Benefits:

MRI

MRA

CT Scans

PET Scans

Nuclear Cardiology Exam

Sclerotherapy

Septoplasty

Any surgical procedure that may be potentially cosmetic: i.e. blepharoplasty, reduction mammoplasty

Hysterectomy

Investigational procedures

Benefits for MRIs, MRAs, CT Scans, PET Scans and Nuclear Cardiology exams will be denied with Pre-Certification is not obtained or approved by the Companion Life. Benefits for any other outpatient services that require Pre-Certification will be reduced by 50% of the Allowable Charge when Pre-Certification is not obtained or approved by the Companion Life.

The coverage for Members may terminate on any given day during the term of this Plan of Benefits.

SCHEDULE OF BENEFITS

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital charges for room and board related to Admissions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient physical rehabilitation services (limited to a lifetime maximum payment of \$100,000) when Pre-Certified by the Companion Life and performed at a Provider designated by the Companion Life	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Skilled Nursing Facility Admissions (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Long Term Acute Care Hospital (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services performed at an independent laboratory facility	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
True Emergency Room Visits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Non-true Emergency Room Visits (Copayment waived if admitted)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$50 Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$100 Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other covered outpatient Benefits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Physician Services in a Hospital	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Physician services for lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Services in the Physician's office (other than Mental Health Services, Mental Health Conditions, Maternity Care, Substance Abuse Services, physical therapy, dialysis treatment and second surgical opinion)	<p>The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services in the Covered Person's home	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Second surgical opinion	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Physician Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES

Mental Health and Substance Abuse Services are limited to a combined total of thirty (30) days of inpatient care (Admission) or twenty (20) outpatient appointments per Covered Person per Benefit Year. This combined total does not apply to Mental Health Conditions. As with all other Benefits, Covered Expenses included in this section apply to the Lifetime Maximum. Additionally, there is a \$10,000 lifetime maximum payment for Substance Abuse Services for each Covered Person. Pre-Certification is required for Mental Health Services, Mental Health Conditions and Substance Abuse Services. If Pre-Certification is not obtained or approved by the Companion Life, the following penalties will apply.

**Inpatient: Denial of room and board
Outpatient: 50% of the Allowable Charge
Office: 50% of the Allowable Charge**

	Participating Provider	Non-Participating Provider
Inpatient Hospital charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Hospital charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Hospital charges for Substance Abuse Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient Hospital or clinic charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Substance Abuse Services and for the treatment of Alcohol Abuse	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Medically necessary services for the treatment of autism spectrum disorders (ASD) when the criteria of the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR) are met	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Inpatient Physician charges for Substance Abuse Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient or Office Physician charges for Mental Health Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient Physician charges for Mental Health Conditions	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Office Physician charges for Mental Health Conditions	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient or Office Physician charges for Substance Abuse Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES		
	Participating Provider	Non-Participating Provider
Ambulance service: Ground transport to and from a Hospital in an ambulance (benefit includes air ambulance)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Durable Medical Equipment, Prosthetics and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is \$500 or more, Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services.	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Medical Supplies	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p>
Home Health Care, including private duty nursing services (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Maternity	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Hospice Care (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Provider Charges for physical therapy and occupational therapy (Limited to a \$1,000 combined maximum Benefit per Covered Person per Benefit Year. Please see the "Outpatient Rehabilitation" section in Section IV for further limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Speech therapy (Please "Outpatient Rehabilitation" in Section IV for limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
<p>Radiation therapy</p> <p>Cancer chemotherapy</p> <p>Respiratory therapy</p> <p>Pre-certification is required</p>	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)																																						
	Participating Provider	Non-Participating Provider																																				
Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy.	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider’s charge																																				
In Vitro Fertilization	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider’s charge																																				
Human organ and tissue transplant services (excluding drugs), limited to a \$250,000 maximum payment per Covered Person per lifetime and with the following individual organ transplant limits: <table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Bone Marrow/Stem Cell</td> <td style="width: 10%; text-align: right;">\$250,000</td> <td></td> </tr> <tr> <td>Cornea</td> <td style="text-align: right;">\$ 25,000</td> <td></td> </tr> <tr> <td>Heart</td> <td style="text-align: right;">\$120,000</td> <td></td> </tr> <tr> <td>Heart/Lung</td> <td style="text-align: right;">\$130,000</td> <td></td> </tr> <tr> <td>Heart/Lung (double)</td> <td style="text-align: right;">\$250,000</td> <td></td> </tr> <tr> <td>Kidney</td> <td style="text-align: right;">\$ 60,000</td> <td></td> </tr> <tr> <td>Kidney (double)</td> <td style="text-align: right;">\$120,000</td> <td></td> </tr> <tr> <td>Lung (double)</td> <td style="text-align: right;">\$250,000</td> <td></td> </tr> <tr> <td>Lung/Segmental Lung</td> <td style="text-align: right;">\$130,000</td> <td></td> </tr> <tr> <td>Liver/Segmental Liver</td> <td style="text-align: right;">\$225,000</td> <td></td> </tr> <tr> <td>Pancreas</td> <td style="text-align: right;">\$ 80,000</td> <td></td> </tr> <tr> <td>Pancreas and Kidney</td> <td style="text-align: right;">\$ 80,000</td> <td></td> </tr> </table> Human organ and tissue transplant services are only covered if provided at a transplant center approved by the Company in writing Physician Charges are subject to the Benefit Year Deductible.	Bone Marrow/Stem Cell	\$250,000		Cornea	\$ 25,000		Heart	\$120,000		Heart/Lung	\$130,000		Heart/Lung (double)	\$250,000		Kidney	\$ 60,000		Kidney (double)	\$120,000		Lung (double)	\$250,000		Lung/Segmental Lung	\$130,000		Liver/Segmental Liver	\$225,000		Pancreas	\$ 80,000		Pancreas and Kidney	\$ 80,000		The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible and Copayment	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible and Copayment The Covered Person must pay the balance of the Provider’s charge
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SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Allergy Injections	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Acupuncture	Non-Covered	Non-Covered
Chiropractic Services, including related x-rays, modalities and office visits, limited to a \$500 maximum payment and 20 visits per Covered Person per Benefit Year	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Cosmetic Services	Non-Covered	Non-Covered
Disease Management Program	Covered	Non-Covered
Health Questions Hotline	Covered	Non-Covered
Hearing Aids	Non-Covered	Non-Covered
Oxygen (Pre-Certification is required)	Covered	Covered
Impacted tooth removal	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 60% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Impotence treatment	Non-Covered	Non-Covered
Online Health Assessment Program	Covered	Non-Covered
Massage Therapy	Non-Covered	Non-Covered
Maternity Management Program	Covered	Non-Covered
Tobacco Cessation Program	Covered	Non-Covered

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Speech or Hearing Impairment	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Temporomandibular Joint Disorder (TMJ) including treatment, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Orthognathic surgery, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Phenylketonuria (PKU) Formula	Covered	Covered
Weight Control Program	Covered	Non-Covered
Supplemental Accident benefits (the first \$300 incurred per Benefit Year is payable at 100% and is not subject to the Benefit Year Deductible)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 60% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

ANNUAL BENEFITS The Benefit Year Deductible does not apply to these Benefits.		
	Participating Provider	Non-Participating Provider
Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	Non-Covered
Physical exam (limited to \$250 per Covered Person per Benefit Year for Covered Persons 40 or older)	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Prostate examination, screenings, and laboratory work (limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	Non-Covered
Colorectal Cancer Screenings (limited to: <ul style="list-style-type: none"> • One (1) fecal occult blood testing of three consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy once every five years • One (1) double contract barium enema every five years • One (1) colonoscopy every ten years) 	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Well child care performed in the Physician's office and immunizations for Dependents up to age 6	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Gynecological exam (limited to two (2) per Benefit Year) The \$250 per Covered Person per Benefit Year physical exam maximum will apply. Once this maximum is met the contract Benefit Year Deductible and Coinsurance will apply.	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Mammography screenings: <ul style="list-style-type: none"> • One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. • A mammogram once every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician. • A mammogram every year for any woman who is fifty (50) years of age or older. <p style="margin-left: 20px;">Such coverage shall not exceed the cost of the examination.</p>	The Company pays 100% of Allowable Charge	Non-Covered

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Generic Drugs	The Covered Person pays a \$20 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 90-day supply	The Covered Person pays a \$10 Copayment after meeting the Covered Member's Benefit Year Deductible, up to a 31-day supply	The Company pays 100% of the Allowable Charge after a \$10 Copayment per Covered Person and after the Benefit Year Deductible, up to a 31-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Preferred Brand Drug	The Covered Person pays a \$55 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 90-day supply	The Covered Person pays a \$25 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 31-day supply	The Company pays 100% of the Allowable Charge after a \$25 Copayment per Covered Person and after the Benefit Year Deductible, up to a 31-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Non-Preferred Brand Drug	The Covered Person pays a \$95 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 90-day supply	The Covered Person pays a \$40 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 31-day supply	The Company pays 100% of the Allowable Charge after a \$40 Copayment per Covered Person and after the Benefit Year Deductible, up to a 31-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Contraceptives (Prescription Drugs)	Covered	Covered	Covered
Prescription Drugs used for smoking cessation	Covered	Covered	Covered
Prescription Drug Deductible*	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG BENEFIT (CONTINUED)			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Maximum Prescription Drug Benefit	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)
Prescription Drugs used for obesity/weight control	Non-Covered	Non-Covered	Non-Covered
Diabetic syringes and supplies	Covered	Covered	Covered

*The Prescription Drug deductible is integrated in the Benefit Year Deductible. Once the Benefit Year Deductible is satisfied the Prescription Drug deductible is satisfied, and the Covered Person is only responsible for remaining Copayment.]

[About Health Savings Accounts

This high deductible policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This contract may qualify you to make a pre-tax annual contribution to a Health Saving Account (HSA).

The high Deductible Plan is not a “health savings account” or an “HSA,” but is designed as an HSA compatible high deductible health plan that may allow you, if you are an eligible individual, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the Deductible under this Contract.

NOTICE: The Company does NOT provide tax advise. If you intent to purchase this Contract to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

This Contract is designed to meet government requirements for an HSA compatible high Deductible health Contract to be used in conjunction with establishing eligibility for HSA tax benefits. Although the Company believes that the Contract meets these requirements, the Internal Revenue Service has not ruled on whether the Contract is qualified as an HSA compatible high Deductible health Contract.

Should you purchase this Contract in order to obtain income tax benefits associated with an HSA, and the Internal Revenue Service were to rule this Contract does not qualify as a high Deductible health Contract, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.]

Section I - Definitions

1. “Accident” means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.
2. “Accidental Dental Injury” means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for disease or illness.
3. “Actively-At-Work” means You will be considered to be actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the Usual way, all of the regular duties of Your job on a full time basis on that day. You will be deemed to be actively at work on a day which is not one of Your Employer's scheduled work days only if You Were actively at work on the preceding scheduled work day.
4. “Admission” means the period of time between an Insured Person’s entry as an Inpatient into a Hospital or Skilled Nursing Facility and the time the Insured Person leaves or is discharged from the Hospital or Skilled Nursing Facility.
5. “Adoption or Adopt(ed)” means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents.
6. “Adverse Benefit Determination” means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Evidence of Coverage with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.
7. “Allowance” means the maximum amount upon which payment will be based for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered was not a PPO provider. This Allowance is determined and established solely by Companion Life and is based upon many factors. Such factors may (but not necessarily will) include: pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area established by Companion Life; and/or the cost of providing the Covered Service. The Allowance may be modified by Companion Life at any time without the consent or notice to the Employer or any Covered Plan Participant.
8. “Allowed Amount” means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount is the PPO Schedule Amount when the Provider who rendered the Covered Service(s) was a Preferred PPO Provider, and the Allowance when the Provider who rendered the Covered Service(s) was not a Preferred PPO Provider. Further, under the Group Health Plan Program, the allowed Amount means the maximum amount upon which Companion will base payment to the applicable Host Plan for Covered Services provided in the applicable Host Plan’s geographic area. Each Allowed Amount is determined and established by Companion Life and is subject to change at any time without notice to or consent of the Employer or any Covered Plan Participant.

Section I – Definitions (Continued)

9. “Ambulance” means a ground or water vehicle, airplane or helicopter properly licensed pursuant to applicable law in the state of issue.
10. “Ambulatory Surgical Center” means a facility properly licensed, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.
11. “Anniversary Date” means the date, one year after the Effective date and subsequent annual anniversaries of that date.
12. “Application For Group Insurance/Membership” means the Companion Life form that individual(s) must submit to the Employer when applying for coverage during the 30-day period immediately following the date that individual(s) first became eligible for coverage under the Policy, or as part of the Employer’s initial enrollment.
13. “Artificial Insemination (AI)” means a medical procedure in which sperm is placed into the female productive tract by a qualified health care provider for the purpose of producing a pregnancy.
14. “Birth Center” means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.
15. “Bone Marrow Transplant” means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “Bone Marrow Transplant” includes the transplantation as well the administration of chemotherapy and the chemotherapy drugs. The term “Bone Marrow Transplant” also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).
16. “Breast Reconstruction Surgery” means surgery to reestablish symmetry between the two breasts.
17. “Calendar Year” begins January 1st and ends December 31st in any given Calendar Year.
18. “Cardiac Therapy” means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.
19. “Certified Nurse Midwife” means a person who is licensed as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Section I – Definitions (Continued)

20. “Certified Registered Nurse Anesthetist” means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category.
21. “Claim Involving Urgent Care” means any request or application for coverage or benefits for medical care or treatment that has not yet been approved to the Covered Plan Participant with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize the Covered Plan Participant’s life or health or the Covered Plan Participant’s ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Covered Plan Participant’s Condition, would subject the Covered Plan Participant to severe pain that cannot be adequately managed without the proposed services being rendered.
22. “Coinsurance” means the sharing of health expenses for Covered Services between the Policy and the Covered Plan Participant. After the Covered Plan Participant’s Deductible requirement is met, the Policy will pay a percentage of the Allowed Amount for Covered Services, as set forth in the Schedule of Benefits.
23. “Concurrent Care Decision” means a decision by Companion Life and/or the Employer to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if Companion Life and/or the Employer had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.
24. “Condition” means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Covered Plan Participant.
25. “Copayment (if applicable)” means the dollar amount established which is required to be paid to a health care Provider by a Covered Plan Participant at the time certain Covered Services are rendered by that Provider. While this amount may vary depending on, among other things, the contracting status of the health care Provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Benefits for the service. Except as otherwise established, if more than one Covered Service is rendered by a health care Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.
26. “Covered Dependent” means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Policy other than as a Covered Employee.
27. “Covered Employee” means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Policy other than as a Covered Dependent.

Section I – Definitions (Continued)

28. “Covered Plan Participant” means the Covered Employee or Covered Dependent who meets and continues to meet the applicable eligibility requirements of the Employer and is actually covered under the Policy.
29. “Covered Services” means those Medically Necessary Health Care Services described in the Covered Expenses Section. The term Health Care Services includes, as applicable, any treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.
30. “Creditable Coverage” means health care coverage which is continuous to a date within 63 days of the Covered Plan Participant’s Enrollment Date. Such health care coverage may include the following:
1. a group health plan;
 2. individual health insurance
 3. Medicare Part A and Part B;
 4. Medicaid;
 5. benefits to members and certain former members of the uniformed services and their dependents;
 6. a medical care program of the Indian Health Service or a tribal organization;
 7. a State health benefits risk pool;
 8. a health plan offered under chapter 89 of Title 5, United States Code;
 9. a public health plan; or
 10. a health benefit plan of the Peace Corps.
31. “Custodial or Custodial Care” means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient’s diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.
32. “Deductible” means the amount of charges, up to the Allowed Amount, for Covered Services which a Covered Plan Participant must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Policy, before payment for Covered Services begins.
33. “Dependent” means:
- a. an Insured's spouse.
 - b. each unmarried child up to [19]years of age for whom the Insured is legally responsible.
 - c. each unmarried child from age [19 up to age 24] who is:
 - i. a full-time student at an accredited school or college; and
 - ii. primarily dependent on the Insured for support and maintenance.
 - d. each unmarried child age [19] who:
 - i. becomes Totally Disabled while insured under b. or c. above;
 - ii. is incapable of self-sustaining employment because of mental retardation or physical handicap; and

Section I – Definitions (Continued)

- iii. is primarily dependent on the Insured for support and maintenance.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days after the Company asks for it.

- 34. “Detoxification” means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, Covered Plan Participant is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk of the Covered Plan Participant at a minimum.
- 35. “Diabetes Educator” means a person who is properly certified to supervise diabetes outpatient self-management training and educational services.
- 36. “Dialysis Center” means an outpatient facility certified by the Health Care Financing Administration (or a similar regulatory agency in the state of issue) to provide hemodialysis and peritoneal dialysis services and support.
- 37. “Dietitian” means a person who is properly licensed to provide nutrition counseling for diabetes outpatient self-management services.
- 38. “Durable Medical Equipment” means equipment furnished by a supplier or a Home Health Agency that 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.
- 39. “Durable Medical Equipment Provider” means a person or entity that is properly licensed to provide home medical equipment, oxygen therapy services, or dialysis supplies in the patient’s home under a Physician’s prescription.
- 40. “Effective Date” with respect to the Employer and to Covered Plan Participants properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the cover of this Group Health Plan Description; and with respect to Covered Plan Participants who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section of this Evidence of Coverage.
- 41. “Eligible Dependent” means a Covered Employee’s 1) legal spouse and/or 2) natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Covered Employee or the Covered Employee’s legal spouse has been court-appointed as legal guardian or legal custodian) who is :
 - 1. dependent upon the Covered Employee for financial support;
 - 2. under the limiting age set forth in the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage Section; and
 - 3. living in the household of the Covered Employee or a full-time or part-time student.

A newborn child of a Covered Plan Participant other than the Covered Employee or the newborn child of a Covered Plan Participant other than the Covered Employee’s spouse is an Eligible Dependent hereunder. Coverage for such child will automatically terminate 18 months after the birth of the newborn child.

Section I – Definitions (Continued)

42. “Eligible Employee” means an employee who meets all of the eligibility requirements set forth in the Eligibility Requirement for Covered Employees subsection of the Eligibility for Coverage Section, and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee.
43. “Employer” means an entity which has established this plan for the purpose of providing coverage and/or benefits to Coverage Plan Participants.
44. “Endorsement” means any amendment to the Policy or the Certificate of Coverage.
45. “Enrollment Date” means the date of enrollment of the individual under the Policy or, if earlier, the first day of the Waiting Period of such enrollment.
46. “Enrollment Forms” means those forms, which are used to maintain accurate enrollment files under the Policy. Such forms include: the Application for Group Insurance/Membership form and the Member status Change Request form.
47. “Experimental or Investigational” means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined either by the Employer or Companion Life:
1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Plan Participant;
 2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
 3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institution review board or other entity as required and defined by federal regulations;
 4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
 5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
 6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

Section I – Definitions (Continued)

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

“Reliable evidence” shall mean (as determined by the Employer or Companion Life):

1. records maintained by Physicians or Hospitals rendering care or treatment to the Covered Plan Participant or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by the Employer or Companion Life to be Experimental or Investigational are excluded (see the Covered Services Section). In determining whether a Health Care Service is Experimental or Investigational, Companion Life or the Employer may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

48. “Foster Child” means a person under the age of 18 who is placed in the Covered Employee’s residence and care by a regulatory agency in compliance with applicable laws.
49. “Gamete Intrafallopian Transfer (GIFT)” means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.
50. “Group Health Plan Description” means the written document (Policy) whereby coverage and/or benefits will be provided to Covered Plan Participants. The Group Health Plan Description includes the Certificate of Coverage, the Application for Group Insurance/Membership, the Member Status Change Request form, and any Endorsements to the Group Health Plan Description or the Certificate of Coverage.

Section I – Definitions (Continued)

51. “Health Care Services” includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.
52. “Home Health Care or Home Health Care Service” means Physician-directed professional, technical and related medical and personal care services provided on a visiting or part-time basis directly by (or indirectly through) a Home Health Agency in the Covered Plan Participant’s home or residence.
53. “Hospice” means a public agency or private organization which is duly licensed to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.
54. “Hospital” means a facility properly licensed that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial Care, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

55. “Identification Care” means the card(s) issued by Companion Life to the Covered Employees. The card is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the Policy.
56. “Independent Clinical Laboratory” means a laboratory properly licensed where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.
57. “Independent Diagnostic Testing Facility” means a facility, independent of a hospital or physician’s office, which is a fixed location, a mobile entity, or an individual non-physician practitioner where diagnostic tests are performed by a licensed physician or by a licensed, certified non-physician personnel under appropriate physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable laws of the State in which it operates. Further, such an entity must meet Companion Life’s criteria for eligibility as an Independent Diagnostic Testing Facility.

Section I – Definitions (Continued)

58. “In Vitro Fertilization (IVF)” means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the women’s uterus.
59. “Licensed Practical Nurse” means a person properly licensed to practice practical nursing pursuant to applicable state law(s).
60. “Massage or Massage Therapy” means the manipulation of superficial tissues of the human body by using the hand, foot, arm, or elbow.
61. “Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.
62. “Medically Necessary or Medical Necessity” means, for coverage and payment purposes only, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of the Employer or Companion Life:
1. consistent with the symptom, diagnosis, and treatment of the Covered Plan Participant’s Condition;
 2. widely accepted by the practitioners’ peer group as efficacious and reasonably safe based upon scientific evidence;
 3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
 4. not Experimental or Investigational;
 5. not for cosmetic purposes;
 6. not primarily for the convenience of the Covered Plan Participant, the Covered Plan Participant’s family, the Physician or other provider; and
 7. the most appropriate level of service, care or supply which can safely be provided to the Covered Plan Participant. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Covered Plan Participant in an alternative setting.
63. “Medicare” means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.
64. “Member Status Change Request” form means the form(s) provided by or acceptable to Companion Life, which a Covered Employee must complete and submit through the Employer and received by Companion Life, when adding or deleting a Covered Dependent.
65. “Mental Health Professional” means a person properly licensed to treat Mental and Nervous pursuant to applicable laws of the state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling services.
66. “Mental and Nervous Disorders” means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Section I – Definitions (Continued)

67. “Midwife” means a person properly licensed by midwifery pursuant to applicable state law(s).
68. “Morbid Obesity is a Condition” where a Covered Plan Participant is 100 pounds over their ideal body weight and/or Body Mass Index (BMI) of equal to or greater than 40.
69. “Occupational Therapy” means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.
70. “Orthotic Device” means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.
71. “Outpatient Rehabilitation Facility” means an entity which renders, through providers properly licensed pursuant to law(s) of the state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet Companion’s criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit or a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III “specialty rehabilitation hospital” described in applicable state law(s).
72. “Partial Hospitalization” means treatment in which the patient receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a “home” for purposes of this definition.
73. “Physical Therapist” means a person properly licensed to practice Physical Therapy pursuant to applicable state law.
74. “Physical Therapy” means the treatment of disease or injury by physical or mechanical means as defined in applicable state law(s). Such therapy may include traction, active or passive exercises, or heat therapy.
75. “Physician” means any individual who is properly licensed by applicable state law as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).
76. “Physician Assistant” means a person licensed pursuant to applicable state law(s).
77. “Placed, Placement, or To Place” means to the process of a person giving a child up for Adoption and the prospective parent receiving and Adopting the child, or the process where a Foster Child will reside with and be cared for by the Covered Plan Participant and includes all actions by any person or agency participating in the process, or as otherwise defined by applicable State Statutes.

Section I – Definitions (Continued)

78. “Post-Service Claim” means any paper or electronic request or application for coverage, benefits, or payment for a service actually provided to the Covered Plan Participant (not just proposed or recommended) that is received by Companion Life on a properly completed claim form or electronic format acceptable to Companion Life in accordance with the provisions of this section.
79. “PPO” means, or refers to, the network of PPO Providers available to Covered Plan Participants under this Evidence of Coverage.
80. “PPO Provider” means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to a Covered Plan Participant, was under contract with Companion Life to participate in Companion Life’s network of preferred Providers.
81. “PPO Schedule Amount” means the amount on which payment will be based for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was a Preferred PPO Provider. This amount is determined and established by Companion Life and is a pre-established maximum schedule amount which may vary by geographical area.

The amount of charges credited to the Deductible requirement will not exceed the Allowed Amount.

82. “Pre-Existing Condition” means medical advice, diagnosis, care, or treatment within the 6 month period ending on the enrollment date, and which extends for not more than 12 months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or 18 months after the enrollment date in the case of a late enrollee.

The Pre-existing Condition exclusionary period does not apply to:

1. pregnancy;
 2. a newborn child or an adopted newborn child;
 3. an adopted child who is covered under Creditable Coverage;
 4. Genetic Information in the absence of a diagnosis of the Condition;
 5. routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or
 6. Conditions arising from domestic violence.
83. “Pregnancy” means a Covered Person’s normal Pregnancy and the resulting normal childbirth, elective cesarean section or elective abortion.
84. “Pre-Service Claim” means any request or application for coverage or benefits for a service that has not yet been provided to the Covered Plan Participant and with respect to which the terms of the Policy condition payment for the service (in whole or in part) on approval by Companion Life and/or the Employer of coverage or benefits for the service before the Covered Plan Participant receives it. A Pre-Service Claim may be a Claim involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by Companion Life and/or the Employer regarding coverage, benefits, or payment for a service that has not actually been rendered to the Covered Plan Participant if the terms of the Policy do not require (or condition payment upon) approval by Companion Life and/or the Employer of coverage or benefits for the service before it is received.

Section I – Definitions (Continued)

85. “Prosthetist/Othotist” means a person or entity that is properly licensed to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs under a Physician’s prescription.
86. “Prosthetic Device” means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.
87. “Provider” means any facility, person or entity recognized for payment by Companion Life and defined in the Policy.
88. “Psychiatric Facility” means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Policy, a Psychiatric Facility is not a Hospital, as defined herein.
89. “Psychologist” means a person properly licensed to practice psychology pursuant to applicable state law(s).
90. “Registered Nurse” means a person properly licensed to practice professional nursing pursuant to applicable state law(s).
91. ”Registered Nurse First Assistant (RNFA)” means a person properly licensed to perform surgical first assisting services pursuant to applicable state law(s).
92. “Rehabilitative Therapies” means therapies the primary purpose of which is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but is not limited to, Physical Therapy, Speech Therapy, pain management, pulmonary therapy or Cardiac Therapy.
93. “Skilled Nursing Facility” means an institution or part thereof which meets Companion Life’s criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the State or similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by Companion Life.
94. “Speech Therapist” means a person properly licensed to practice Speech Therapy pursuant to applicable law.
95. “Speech Therapy” means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy services.
96. “Standard Reference Compendium” means: 1) The United States Pharmacopoeia Drug Information; 2) The American Medical Association Drug Evaluation; or 3) The American Hospital Formulary Service Hospital Drug Information.

Section I – Definitions (Continued)

97. “Substance Abuse Facility” means a facility properly licensed under applicable law to provide necessary care and treatment for Substance Dependency Care. For purposes of this Policy, a Substance Abuse Facility is not a Hospital.
98. “Substance Dependency” means a Condition where a person’s alcohol or drug use injures his or her social or economic functioning; or causes the individual to lose self-control.
99. “Traditional Insurance Providers” are those health care Providers who are not PPO Providers, but who or which have entered into a contract then in effect to participate in Companion Life’s traditional provider programs when such programs exist.
100. “Waiting Period” means the period of time specified if any, which must follow the date an individual is initially employed by the Employer before such individual may become a Covered Plan Participant.
101. “Zygote Intrafallopian Transfer (ZIFT)” means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

Section II – Eligibility and Enrollment

Eligibility

A. Eligible Class(es)

[All Full-Time Employees of the Employer]

B. Eligibility Date - Employee Insurance

1. Each Employee in an eligible class on the Policy Effective Date is eligible to be insured under this Policy on [that date.][the later of the Policy Effective Date or the day after he or she completes the Waiting Period selected by the Employer.]
2. An Employee who enters an eligible class after the Policy Effective Date is eligible to be insured under this Policy on [the day he or she enters an eligible class.][the day after he or she completes the Waiting Period selected by the Employer.]
3. An Employee who is insured, or eligible to be insured, under this Policy and then is laid off or put on a leave of absence and is then rehired by the Employer is considered a newly hired Employee. The provisions of this Policy which are applicable to newly hired Employees and their Eligible Dependents are applicable to rehired Employees and their Eligible Dependents.

C. The following individuals who meet the eligibility criteria specified below as an Eligible Dependent is eligible to apply for coverage under this Policy:

1. the Covered Employee's present spouse;
2. the Covered Employee's natural, newborn, adopted, foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year, in which the child reaches age 25, and who is:
 - a. dependent upon the Covered Employee for financial support; and
 - b. living in the household of the Covered Employee or a full-time or part-time student.
3. the newborn child of a Covered Plan Participant other than the Covered Employee or the newborn child of a Covered Plan Participant other than the Covered Employee's spouse. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.
4. Handicapped children – A handicapped dependent child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if such child is otherwise eligible for coverage under this Policy, incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of such child's handicap existed prior to such child's 25th birthday. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

Note: It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section II – Eligibility and Enrollment (Continued)

D. Eligibility Date - Dependent Insurance

Each Employee in a class eligible for Dependent insurance is eligible to have his or her Dependents insured under this Policy on the later of:

1. the date the Employee becomes eligible for Employee insurance under this Policy; or
2. the date the Employee first acquires a Dependent.

No person may be insured simultaneously as an Employee and as a Dependent under this Policy. No person may be insured simultaneously as a Dependent of more than one Employee under this Policy.

E. The following individuals may be added upon becoming an eligible Dependent of a Covered Employee:

1. **Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit a Member status Change Request form through the Employer to Companion Life prior to or during the 90-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

Companion Life must be notified, in writing, within 30 days after the birth. In the event the Employer is not notified before or within 90 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period.

Note: Coverage for a newborn child of a Covered Plan Participant other than the Covered Employee or the Covered Employee's spouse will automatically terminate 18 months after the birth of the newborn child.

2. **Adopted Newborn Child** – To enroll an Adopted child, the Covered Employee must submit a Member Status Change Request form through the Employer to Companion Life prior to or during the 60-day period immediately following the filing of the petition for adoption.

Effective Date of coverage for an Adopted newborn child, eligible for coverage, shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. Any Pre-existing Condition exclusionary period will not apply. The Employer may require the Covered Employee to provide any information and/or documents which Companion Life deems necessary in order to administer this provision.

In the event the Employer is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Employee provides notice to the Employer, and Companion Life receives the Member Status Change Request form within 60 days of the birth. In the event Companion Life is not notified before or within 60 days of the date of birth, the Covered Employee must make application during an Annual Open Enrollment Period.

If the Adopted newborn child is not ultimately Placed in the residence of the Covered Employee, there shall be no coverage for the Adopted newborn child. It is the responsibility of the Covered Employee to notify the Employer within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

Section II – Eligibility and Enrollment (Continued)

3. **Adopted/Foster Child** – To enroll an Adopted or Foster Child, the Covered Employee must submit a Member Status Change Request form through the Employer to Companion Life prior to or during the 30-day period immediately following the date of Placement. The Effective Date for an Adopted or Foster child (other than an Adopted newborn child) shall be the date such Adopted or Foster child is Placed in the residence of the Covered Plan Participant in compliance with applicable law. Any Pre-existing Condition exclusionary period will not apply to an Adopted child but will apply to a Foster child. The Employer may require the Covered Employee to provide any information and/or documents which Companion Life deems necessary in order to administer this provision.

In the event the Employer is not notified within 30 days of the date of Placement, the child will be added as of the date of Placement so long as the Covered Employee provides notice to the Employer, and Companion Life receives the Member Status Change Request form within 60 days of the Placement. In the event Companion Life is not notified before or within 60 days of the date of Placement, the Covered Employee must make application during an Annual Open Enrollment Period.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted Child. Proof of final Adoption must be submitted to Companion Life. It is the responsibility of the Covered Employee to notify the Employer if the Adoption does not take place. Upon receipt of this notification, Companion Life will terminate the coverage of the child on the first billing date following receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Covered Employee to notify Companion Life that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, Companion Life will terminate the coverage of the child on the first billing date following receipt of the written notice.

4. **Marital Status** – A Covered Employee may apply for coverage of an Eligible Dependent(s) due to marriage. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through the Employer to Companion Life. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent(s) who is enrolled as a result of marriage is the date of the marriage.
5. **Court Order** – A Covered Employee may apply for coverage of an Eligible Dependent outside of the initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee's plan. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through the Employer to Companion Life. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Section II – Eligibility and Enrollment (Continued)

F. Dependents Not Eligible for Benefits

The following Dependents are not eligible for benefits under this Policy in any case:

1. an Employee's former spouse who is legally divorced from the Employee, unless a court order decree directs otherwise, and then only until either the Employee or ex-spouse remarries;
2. an eligible Employee's Child nineteen (19) or more years of age, with the exception of:
 - a. an unmarried Child, nineteen (19) or more years of age who is unable to earn his or her own living due to physical or mental Illness or handicap; and
 - b. an unmarried Full-Time Student.

G. Continuation of Eligibility due to Mental or Physical Handicap

If an unmarried Child, who is insured under this Policy or was insured under a similar contract held by the Employer that this Policy replaces, is unable to earn his or her own living due to physical or mental Illness or handicap and he or she is at or reaches a terminating age under the terms of this Policy, he or she will be eligible under this Policy if Companion Life receives proof, satisfactory to Companion Life, that the Child is unable to earn his or her own living due to physical or mental Illness or handicap. The proof must be received within 60 days after the later of:

1. the date the Dependent becomes eligible under this Policy; or
2. the date the Dependent reaches a terminating age under the terms of this Policy.

Companion Life reserves the right to require subsequent proof of incapability during the time the Dependent remains insured under this Policy. Proof will not be required more than once per year after the first year the Dependent remains insured under this provision.

Enrollment

To apply for coverage, the Eligible Employee must:

1. complete and submit, through the Employer, the Application for coverage under this Policy.
2. provide any additional information needed to determine eligibility, if requested by Companion Life.
3. complete and submit, through the Employer, a Member Status Change Request form to add Eligible Dependents or delete Covered Dependents.

Section II – Eligibility and Enrollment (Continued)

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Employer's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.
2. Employee/Spouse Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's present lawful spouse only.
3. Employee/Child(ren) Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's child(ren) only.
4. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

A. Enrollment Periods – The enrollment periods for applying for coverage are as follows:

1. Initial Enrollment Period is the period of the time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.
2. Annual Open Enrollment Period is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives, included in the Employer's health benefit program.
3. Special Enrollment Period is the 30-day period of time immediately following a special circumstances during which an Eligible Employee or Eligible Dependent may apply for coverage.

B. Employee Enrollment

1. An individual who is an Eligible Employee on the Employer's Effective Date must Enroll during the Initial Enrollment Period. The Eligible Employee shall become a Covered Employee as of the Effective Date of the Employer. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Covered Employee's Effective Date.
2. An individual who becomes an Eligible Employee after the Employer's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will be on the date specified on the Group Application.

Section II – Eligibility and Enrollment (Continued)

C. Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Application for Group Insurance/Membership form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period. Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

D. Special Enrollment Period

An Eligible Employee who declined coverage in writing at the time of his/her Initial Enrollment Period may apply for coverage due to loss of eligibility for coverage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the applicable Enrollment Form and forward it to his/her Employer. The Eligible Employee must make application for enrollment within 30 days of the special circumstance.

Loss of Eligibility of Coverage – An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

1. was covered under another group health benefit plan as an employee or dependent, or was covered under other health insurance coverage or, was covered under COBRA continuation of coverage at the time he or she was initially eligible to enroll for coverage under the Group Health Plan Description;
2. when offered coverage at the time of initial eligibility, stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment;
3. demonstrates that he or she has lost coverage under a group health benefit plan or health insurance coverage within the past 30 days as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage; and
4. requests enrollment within 30 days after the termination of coverage under another employer health benefit plan.

An individual who loses coverage as a result of termination for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) does not have the right to make application for coverage during the Special Enrollment Period.

Section II – Eligibility and Enrollment (Continued)

E. Special Circumstances

An Eligible Employee may apply for coverage due to the following special circumstances:

1. birth of a child;
2. Placement for adoption; or
3. marriage.

Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete and submit the Application for Group Insurance/Membership form through the Employer to Companion Life. The Eligible Employee must make application for enrollment within 30 days of the special circumstance. The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) who are enrolled as a result of birth, Adoption, Placement for Adoption, or marriage is the date of the event. Any Pre-existing Condition exclusionary period will not apply to a newborn child or Adopted child.

Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period. (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee.)

Section III - Effective Date of Insurance

A. Effective Date

1. Employee

An Employee's insurance under this Policy begins on the [XXth of the month that coincides with or next follows the] latest of the following dates:

- a) the date the Employee becomes eligible;
- b) the date the Employee enrolls in writing, if required;
- c) the date the Employee agrees to make any required premium contribution;
- d) the date Companion Life approves any required Evidence of Insurability for the Employee.

However, if the Employee is not Actively at Work on the date his or her insurance otherwise would begin, his or her insurance will not begin on that date but will instead begin on the first day the Employee is again Actively at Work.

2. Dependent

A Dependent's insurance under this Policy begins on the [XXth of the month that coincides with or next follows the] latest of the following dates:

- a) the date the Employee's insurance for himself or herself begins;
- b) the date the Employee enrolls for insurance for that Dependent in writing, if required;
- c) the date the Employee agrees to make any required premium contribution for that Dependent's insurance;
- d) the date Companion Life approves any required Evidence of Insurability for that Dependent.

However, if the Dependent is confined at home or in a Hospital or other facility on the date his or her insurance otherwise would begin, or is unable to engage in all the normal activities of a person in good health of like age and sex on that date, his or her insurance will not begin on that date but will instead begin on first date the Dependent both: (1) is no longer so confined; and (2) is able to engage in all the normal activities of a person in good health of like age and sex.

Section III - Effective Date of Insurance (Continued)

3. Changes in Benefits

Any change in benefits under this Policy applies with respect to any Insured Employee or Insured Dependent on the effective date of the Policy amendment to provide the change in benefits. However, with respect to any change that is an enhancement, improvement, or increase in benefits:

- a) if an Insured Employee is not Actively at Work on that day, the change will not apply with respect to that Employee until the first day he or she again is Actively at Work.
- b) if an Insured Dependent is confined at home or in a Hospital or other facility on that day, or is unable to engage in all the normal activities of a person in good health of like age and sex on that day, the change will not apply with respect to that Dependent until the first day the Dependent both: (1) is no longer so confined; and (2) is able to engage in all the normal activities of a person in good health of like age and sex.

B. Minimum Participation Requirements

For this Policy to remain in effect, the following minimum participation requirements must be satisfied:

1. Contributory Coverage

For Contributory Employee insurance, the Employer is required to maintain a minimum participation of [seventy-five percent (75%)] of eligible Employees not covered elsewhere. For Contributory Dependent insurance, the Employer is required to maintain a minimum participation of [seventy-five percent (75%)] of those eligible Employees not covered elsewhere with one or more eligible Dependents.

2. Non-Contributory Coverage

For Non-Contributory Employee insurance, the Employer is required to maintain a minimum participation of one hundred percent (100%) of eligible Employees. For Non-Contributory Dependent insurance, the Employer is required to maintain a minimum participation of one hundred percent (100%) of those eligible Employees with one or more eligible Dependents.

Failure to maintain the minimum participation requirements as described in (1) and (2) above will cause this Policy to terminate.

C. Additional Insured Persons

Additional Employees and Dependents may from time to time be added to the group originally insured when:

1. an Employee becomes eligible for insurance according to the provisions herein; and/or
2. a Dependent becomes eligible for insurance according to the provision herein.

Section IV – Covered Expenses

Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of this Plan of Benefits and the Schedule of Benefits. The total amount paid for Benefits shall not exceed the Lifetime Maximum and in the event that a Covered Person reaches the Lifetime Maximum, no further Benefits will be paid under this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will only be paid for Benefits:

1. Performed or provided on or after the Covered Person's Effective Date; and
2. Performed or provided prior to termination of coverage; and
3. Provided by a Physician, within the scope of his or her license; and
4. For which the appropriate Preadmission Review, Emergency Admission Review, Pre-Certification and/or Continued Stay Review has been requested and Pre-Certification was received from the Company; and
5. That are Medically Necessary; and
6. That are not subject to an exclusion under Section VII; and
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

Assignment of Covered Expenses

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

Specific Covered Benefits

If all of the following requirements are met the Company will provide the Benefits described and listed under Benefits of Section IV.

1. All of the requirements of this Section IV must be met.
2. The Benefit must be listed in this Section IV.
3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits.
4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits.
5. The Benefit must not be subject to one or more of the exclusions set forth in Section VII.

Section IV – Covered Expenses (Continued)

Benefits

Allergy Injections

The Company will pay Covered Expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,
2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) dose; and,
3. When any of the following conditions are met:
 - a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,
 - b. The patient has a life threatening allergy to insect stings; or,
 - c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,
 - d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

Ambulance

The Company will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:

1. Locally to or from a Hospital providing Medically Necessary service in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,
2. To or from a Hospital in connection with an Admission.

Chiropractic Services

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a “Non-Covered” notation, the Company will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Cleft Lip or Palate

The Company will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;
2. Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Prosthodontia treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and
7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Pre-Certified. If a Covered Person with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan of Benefits. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.

Colorectal Cancer Screening

The Company will pay Covered Expenses for a colorectal cancer screening regardless of Medical Necessity as outlined on the Schedule of Benefits. The Company will pay Covered Expenses for additional colorectal cancer screenings during a Benefit Year based on Medical Necessity.

Contraceptives

Coverage shall be provided for prescription contraceptive drugs or devices, including oral contraceptive and devices (IUD); subdermal contraceptive implants (Norplant) and related Treatments, Services and Supplies. Covered Expenses include the insertion or removal of and any Medically Necessary examination associated with the use of the prescribed contraceptive drug or device.

Dental Care for Accidental Injury

The Company will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Covered Person is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Certification; however, the dentist must submit a plan for any future treatment to the Company for review and Pre-Certification before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Diabetes Self-Management and Supplies

The Company will pay Covered Expenses for outpatient self-management training and education for Covered Persons with diabetes mellitus provided that such training and educational Benefits are rendered by a Physician whose program is recognized by the American Diabetes Association.

Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for an individual that meets the conditions specified in the plan. A Covered Person who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

Benefits will be paid for Covered Expenses incurred by a Covered Person for Medically Necessary equipment and related supplies for the treatment of diabetes when prescribed by a Doctor or other licensed health care provider.

Equipment and related supplies which may be Medically Necessary include, but are not limited to, the following:

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Diabetes data management systems for management of blood glucose;
4. Insulin pumps and equipment for the use of the pump including batteries;
5. Insulin infusion pumps; and
6. Podiatric appliances and therapeutic footwear.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a licensed Doctor.

Disease Management Program

The Company will offer Covered Persons who have an appropriate diagnosis the option to participate in the Company's Disease Management Program. A Covered Person's participation in the Disease Management Program is voluntary.

Durable Medical Equipment

The Company will pay Covered Expenses for standard, non-luxury (as determined by the Company) Durable Medical Equipment. The Company will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Company will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Covered Person in a Hospital or that the Company determines is included in any Hospital room charge.

Emergency Medical Care

The Company will pay Covered Expenses for health care items and services furnished or required to screen or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Gynecological Examination

The Company will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Covered Persons.

Health Questions Hotline

The Company will provide Covered Persons with access to a 24 hour, health care questions hotline.

Home Health Care

The Company will pay Covered Expenses for Pre-Certified Home Health Care, including private duty nursing, when rendered to a homebound Covered Person in the Covered Person's current place of residence.

Hospice Care

The Company will pay Covered Expenses for Pre-Certified Hospice Care.

Hospital and Skilled Nursing Facility Services

The Company will pay Covered Expenses for Admissions as follows:

1. Semiprivate room, board, and general nursing care;
2. Private room, at semi-private rate as determined by the Company;
3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;
4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
6. In a Long-Term Acute Care Hospital.

Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Covered Person leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Covered Person returns to the Hospital or Skilled Nursing Facility by midnight of the same day. The day a Covered Person enters a Hospital or Skilled Nursing Facility is treated as a day of Admission. The days during which a Covered Person is not physically present for inpatient care are not counted as Admission days.

Human Organ and Tissue Transplants

1. The Company will pay Covered Expenses for certain Pre-Certified human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Covered Person, and provided at a transplant center approved by the Company. Covered Expenses shall only be provided for the human organ and tissue transplants set forth on the Schedule of Benefits.
2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:

Section IV – Covered Expenses (Continued)

Benefits (Continued)

- a. When both the transplant recipient and the donor are Covered Persons, Covered Expenses will be paid for both.
 - b. When the transplant recipient is a Covered Person and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
 - c. When the donor is a Covered Person and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.
3. Benefits for human organ and tissue transplants are subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.
 4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.
 5. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under this Plan of Benefits, subject to all of the provisions of this Plan of Benefits as follows:
 - a. Blood transfusions;
 - b. Autologous parathyroid transplants;
 - c. Corneal transplants;
 - d. Bone and cartilage grafting; and
 - e. Skin grafting.

In-Hospital Medical Service

The Company will pay Covered Expenses for a Physician's visit or visits to a Covered Person during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-hospital medical Benefits primarily for Mental Health Services, Mental Health Conditions and Substance Abuse Services;
2. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.
3. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

4. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:
 - a. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant;
 - b. When the surgical procedure performed is designated by the Company as a warranted diagnostic procedure or as a minor surgical procedure.

When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

Mammography Testing

The Company will pay Covered Expenses for mammography testing as set forth on the Schedule of Benefits.

Maternity Management Program

The Company will provide Covered Persons with access to the Maternity Management Program. The Maternity Management Program is designed to assist a Covered Person in receiving prenatal care through coordination with the Covered Person, the Physician, and the Company. The Maternity Management Program is not provided for a Child.

Medical Supplies

The Company will pay Covered Expenses for Medical Supplies, provided that the Company will not pay Covered Expenses separately for Medical Supplies that are provided as part of another Benefit.

Mental Health Conditions

The Company will pay Covered Expenses for Mental Health Conditions.

Mental Health Services

The Company will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

Obstetrical Services

The Company will pay Covered Expenses for Pre-Certified obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Covered Person who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Under the terms of the Newborn and Mother's Health Act of 1996, the Company generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. . In any case, the Company may not require that a Physician obtain certification from the Company for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Certification is required to use certain Physicians or facilities, or to reduce out-of-pocket costs.

Online Health Assessment Program

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a "Non-Covered" notation the Company will provide Covered Persons with access to an online, internet based 24 hour, health care assessment service program.

Orthopedic Devices

The Company will pay Covered Expenses for Pre-Certification Orthopedic Devices.

Orthotic Devices

The Company will pay Covered Expenses for Pre-Certified Orthotic Devices that are not available on an over-the-counter basis.

Outpatient Hospital and Ambulatory Surgical Center Services

The Company will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

Outpatient Rehabilitation Services

The Company will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

Oxygen

The Company will pay Covered Expenses for Pre-Certified oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Pap Smear

The Company will pay Covered Expenses for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Company will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

Physical Examination

The Company will pay Covered Expenses for an annual physical examination each Benefit Year for Covered Persons that are within the appropriate age guidelines regardless of Medically Necessity.

Physician Services

The Company will pay Covered Expenses for Physician Services, provided that when different levels (as determined by the Company) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Company) of Physician Services.

Prescription Drugs

1. The Company will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Company. Copayments likewise do not change due to receipt of any Credits by the Company.
2. If a Physician prescribes a Brand Name Drug and an equivalent Generic Drug is available (whether or not the Physician indicates in the prescription that the substitution of a Generic Drug is not allowed), any difference between the cost of a Generic Drug and the higher cost of a Brand Name Drug shall be the responsibility of the Covered Person.
3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

The Company may, in its sole discretion, place quantity limits on Prescription Drugs.

Prostate Examination

The Company will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Covered Persons that are within the appropriate age guidelines. The Company will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Prosthetic Devices

The Company will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Company) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Covered Person's condition warrants replacement.

Reconstructive Surgery Following Mastectomies

In the case of a Covered Person who is receiving Covered Expenses in connection with a mastectomy; the Company will pay Covered Expenses for each of the following (if requested by such Covered Person):

1. Reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema; in a manner determined in consultation with the attending physician and patient.
4. In addition, the Company will pay Covered Expenses for a minimum of 48 hours of inpatient care following mastectomy, unless a decision of early discharge is made by the attending health care provider and the patient.

Rehabilitation

The Company will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a medical doctor; and
2. All such treatment requires Pre-Certification and must be performed by a Physician and at a location designated by the Company; and
3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Covered Person evaluation from a medical doctor that documents that to a degree of medical certainty the Covered Person has rehabilitation potential such that there is an expectation that the Covered Person will achieve an ability to provide self care and perform activities of daily living; and
5. All such rehabilitation Benefits are subject to periodic review by the Company.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Covered Person is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Routine Annual Benefits

The Company may offer certain routine annual Benefits (typically preventive care) as set forth on the Schedule of Benefits.

Specialty Drugs

The Company will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Covered Person shall not exceed the quantity and benefit maximum set by the Company. Specialty Drugs are medical Benefits. Any medical Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit Maximum will apply as set forth on the Schedule of Benefits. The Covered Person may obtain a list of Specialty Drugs by contacting the Company at the number listed on the Identification Card.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Company. Copayments likewise do not change due to receipt of any Credits by the Company.

Substance Abuse Services

The Company will pay Covered Expenses for Substance Abuse Services as set forth on the Schedule of Benefits.

Surgical Services

The Company will pay Covered Expenses for Surgical Services performed by a medical doctor or oral surgeon for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:
 - a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
 - b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

- c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.
 - d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.
 - e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Company when so requested by the medical doctor or oral surgeon in charge of the case.
 - f. Certain surgical procedures are designated as separate procedures by the Company, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.
2. Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Company will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.
 3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

State Mandated Benefits

The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Year Maximum Benefit amounts shown on the Schedule of Benefits.

Alcohol and Drug Abuse

The Company shall pay expenses for the treatment of alcoholism, chemical dependency or drug addiction when treatment is rendered in: (1) a licensed Hospital; (2) a residential treatment program as licensed by the state of Arkansas pursuant to diagnosis or recommendation by a Doctor of medicine, or (3) a nonresidential treatment program approved or licensed by the state of Arkansas.

Coverage for treatment in a licensed Hospital or residential treatment program shall be limited to 28 days in a policy year. Coverage for treatment in a nonresidential treatment program shall be limited to 130 hours of treatment in a policy year. Notwithstanding anything in this certificate to the contrary, coverage for expenses incurred due to alcohol or drug abuse will be covered the same as any other Sickness.

Dental Hospitalization

The Company will pay Covered Expenses for Hospital, ancillary, and general anesthesia services when rendered in a hospital, outpatient surgical facility, and for associated hospital or facility charges for dental care provided to a dependent child who is under age 5. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

1. The child has a physical, mental, or medically compromising condition; or
2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
3. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
4. The child has sustained extensive orofacial and dental trauma.

In Vitro Fertilization

Coverage is provided for expenses that arise from in vitro fertilization procedures.

Benefits for in vitro fertilization procedures shall be provided to the same extent as benefits provided for other pregnancy-related procedures under the policy.

Coverage for vitro fertilization procedures shall be provided only if:

1. The patient for the in vitro fertilization procedure is a Covered Person under the policy;
2. The fertilization or attempted fertilization of the Covered Person's oocytes is made only with the sperm of the Covered Person's spouse;
3. The Covered Person and the Covered Person's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

Section IV – Covered Expenses (Continued)

State Mandated Benefits (Continued)

4. The Covered Person has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy; and
5. The in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

Maternity Care

The Company will Pay Covered Expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, to the extent shown in the Schedule of Benefits, Certain maternity testing may not be covered under the Policy. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Policy are met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24 - 28 weeks gestation), one ultrasound (subsequent ultrasounds only if they are ordered by a Doctor as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity), and for a Covered Person over age 35, AFP Blood Screening, Amniocentesis/AFP Screening, Chromosome Testing, Fetal Stress/Non-Stress tests. Pre-natal vitamins are not covered.

Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
- b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

PKU Formula

The Company will pay Covered Expenses for nutritional supplements when Medically Necessary, as defined in Section I of this Policy, and when under the direction of a physician on an outpatient basis, either orally or through a tube, for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria.

Speech or Hearing Impairment

The Company will pay benefits for charges for the medically necessary care and treatment of loss or impairment of speech, language or hearing, as well as services performed by a speech and the participant.

Section V – Managed Care

Health Care Coordination

Health care coordination is a program under the Policy conducted by the Case Coordinator which is designated by Us who:

1. identifies cases involving the Covered Person in a clinical situation with the potential for catastrophic claims;
2. assesses such for the appropriateness of the level of patient care and the setting in which it is received;
3. develops, introduces and implements viable Alternate Treatment Plans for such cases that maintain or enhance the quality of patient care;
4. maximizes benefits through implementation of the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Case Coordinator through discussion and agreement with the legal age Covered Person or legal guardian (if necessary), the Physician and Us. It includes:

1. treatment plan objectives;
2. course of treatment planned to accomplish such objectives;
3. responsibility of each party (Case Coordinator, attending Physician and Covered Person and his/her family, if any) in implementing the plan;
4. estimated cost and savings.

If We agree with the Case Coordinator, the attending Physician and the Covered Person on an Alternate Treatment Plan, We may pay incurred Covered Charges at a higher percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Covered Charges under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall be contingent upon written approval by Us or Our authorized Administrator. If such written approval is granted, payment of benefits under the Policy for such services or supplies shall be on the same basis as if such services or supplies were Covered Charges under the terms and provisions of the Policy.

NO COVERED PERSON IS REQUIRED, IN ANY WAY WHATSOEVER, TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE CASE COORDINATOR.

Section VI - Pre-Certification Program

The Pre-Certification Program is applicable to all Inpatient Confinements at a Hospital or Skilled Nursing Facility and any Covered Charges incurred in connection with such Confinement. The Pre-Certification Program also applies to Hospice Confinements and Home Health Care services received, and any Covered Charges incurred in connection with Complications of Pregnancy.

Pre-Certification of Non-Emergency Services

To request Pre-Certification, the Covered Person or the Covered Person's attending Physician must contact the Pre-Certification Service at least seven (7) days in advance. The Pre-Certification Service can be reached by writing or by telephone during normal business hours each business day. The name of the Pre-Certification Service and instructions are provided to each Covered Person.

The Covered Person will be requested to provide:

1. name, address and the telephone number of the attending Physician ;
2. the proposed treatment plan;
3. the Covered Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Certification Service will then consult with the Covered Person's attending Physician. If the Pre-Certification Service concurs with the Covered Person's Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, he or she will so certify in writing to the Covered Person and the Covered Person will be deemed to have complied with the Pre-Certification requirement described herein.

The Pre-Certification Service may also provide a Continued Stay Review. The Continued Stay Review is a process of monitoring a patient's progress on a daily basis to determine if the patient will be discharged within the pre-certified number of days, and to determine the appropriate number of additional days of stay that may be required according to the patient's condition and plan of treatment. All Hospital admissions will be monitored to assure that patients will be discharged on time. The admitting and/or attending Physician(s) and the Hospital utilization review Nurses will be contacted to determine the progress of the patient and the need, if any, for an extension of certified Hospital days. If an extension of the stay is not certified for all or part of the requested day(s), the Covered Person and the admitting and/or attending Physician(s) will be notified.

In absence of Pre-Certification, benefits are subject to Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

No benefits will be paid for Covered Charges incurred for any such Confinement or treatment plan which extends beyond the number of days deemed by the Pre-Certification Service to be Medically Necessary.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

IF THE PRE-CERTIFICATION SERVICE DOES NOT CONCUR WITH THE COVERED PERSON'S PHYSICIAN, THE PRE-CERTIFICATION SERVICE WILL SO NOTIFY THE COVERED PERSON IN WRITING AND THE COVERED PERSON WILL NOT BE DEEMED TO BE IN COMPLIANCE WITH THE PRE-CERTIFICATION REQUIREMENT DESCRIBED HEREIN AND THE FAILURE TO PRE-CERTIFY DEDUCTIBLE WILL APPLY.

Section VI - Pre-Certification Program (Continued)

Pre-Certification of Emergency Care

Emergency Inpatient Confinements must be certified in the same manner as a non-emergency Inpatient Confinement, but the Covered Person or the Covered Person's Physician must contact the Pre-Certification Service within forty-eight (48) hours (or as soon as reasonably possible) of the Emergency Inpatient Confinement. The attending Physician must verify that an Emergency condition existed. In absence of Pre-Certification, benefits are subject to the Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Policy.

Pre-Certification for Complications of Pregnancy and Case Coordination

We require notice to the Pre-Certification Service of Complications of Pregnancy within seven (7) days from the date the Covered Person first obtains such diagnosis.

The Pre-Certification Service can be reached by writing or by telephone during normal business hours each business day. The name of the Pre-Certification Service and instructions are provided to each Covered Person. The Covered Person will be requested to provide:

1. name, address, and the telephone number of the attending Physician (if any);
2. the Covered Person's authorization (or, if a minor, authorization on his or her behalf) to release medical information;

The Pre-Certification Service may then refer the Covered Person or the attending Physician to the Pregnancy Case Coordination Coverage Program which:

1. may help to identify and monitor a Covered Person who is at high risk for premature delivery, or have Pregnancy-induced hypertension;
2. explores appropriate, cost-effective alternatives to lengthy hospitalizations before delivery for high risk mothers; encourages the pregnant Covered Person and newborn in staying healthy through prenatal education.

In the absence of Pre-Certification, benefits are subject to the Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of this coverage.

Failure to Pre-Certify Deductibles

If the Covered Person complies with the Pre-Certification requirement, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits per Hospital Confinement, Skilled Nursing Facility Confinement, Hospice Confinement, or for Home Health Care, will be waived by Us.

If the Covered Person complies with the Pre-Certification requirement for Complications of Pregnancy, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits for such Complications of Pregnancy will be waived by Us. In the event the Covered Person does NOT comply with Pre-Certification, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits will apply only once per Complications of Pregnancy including any Inpatient Confinement in connection with the Pregnancy.

Section VI - Pre-Certification Program (Continued)

This Deductible does not accumulate toward the Calendar Year Deductible amounts or the Individual Out-of-Pocket Maximum amounts.

Pre-Certification Program Appeal Mechanism

The Pre-Certification Program is administered with a built-in appeal process. Issues which are not resolved by the attending Physician and the medical review specialist during the initial evaluation are elevated within the Pre-Certification Service's review program to ensure that the Covered Person's attending Physician has the opportunity to discuss the case with other qualified medical personnel. Prompt attention is given by the Pre-Certification Service to ensure that additional resources are available to work directly with the attending Physician to evaluate the proposed treatment and provide every opportunity to reach an accord.

We do not arrange or provide for the provision of health care services or supplies. It is always the Covered Person's responsibility to select a health care Provider of their choice. We have no control and are not responsible for the actions or lack of actions of any Provider organization pertaining to any medical services rendered to a Covered Person.

Section VII – Exclusions and Limitations

No benefits shall be payable under the Policy for:

1. Expenses incurred by or for a Covered Person in connection with a Pre-Existing Condition as defined in Section I – Definitions, for twelve (12) months after the effective date as shown on the Policy cover page for that Covered Person. No claim for Covered Charges incurred more than twelve (12) months after a Covered Person's effective date will be reduced or denied solely on the grounds that the charge is due to a Pre-Existing Condition, unless the condition is excluded or limited by name or specific description in an amendatory endorsement that is attached to the Policy. This limitation shall not apply to a Dependent child who is adopted or placed for adoption before age eighteen (18), however, expenses incurred before adoption or placement for adoption will not be covered.
2. Any Confinement, treatment, service, supply or prescription which is: (a) not necessitated by a Bodily Injury or Sickness, (b) not authorized by a Physician; (c) not Medically Necessary; (d) not Necessary, Reasonable, and Customary; or (e) not incurred while this coverage is in force.
3. Experimental or Investigational medical treatment as defined in Section I - Definitions.
4. Voluntary abortions.
5. Bodily Injury or Sickness which arises out of or in the course of any employment for wage or profit, nor for a Bodily Injury or Sickness for which the Covered Person has or had a right to compensation under any Workers' Compensation law or occupational disease law, unless specifically amended by the 24-Hour Occupational Coverage Rider attached hereto.
6. Any Confinement, treatment, service or supply provided by a government owned or operated facility, unless the Covered Person is legally required to pay the charges incurred.
7. Bodily Injury or Sickness resulting from war or any act of war (declared or undeclared).
8. Charges incurred while on active duty with any military, naval or air force of any country or international organization.
9. Services and supplies for treatment of: (a) the teeth; and (b) the gums other than for tumors; and (c) any other associated structures primarily in connection with the treatment or replacement of natural teeth; and (d) prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, unless due to an Injury which occurs while covered under the Policy to Natural Teeth, provided that such treatment is received within ninety (90) days following the date of injury.
10. Treatment or surgery as the result of prognathism, retrognathism, micrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an Injury, which occurs while covered under the Policy to Natural Teeth, provided that such treatment is received within ninety (90) days following the date of Injury.
11. Services or supplies to improve the appearance or self perception of a Covered Person, which does not restore a bodily function, including without limitation; cosmetic or plastic surgery, hair loss; or skin wrinkling.

Section VII – Exclusions and Limitations (Continued)

12. Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery.
13. Hearing aids or the fitting thereof.
14. Charges incurred as a result of participation in a riot or insurrection or the commission of a felony or while imprisoned.
15. Charges for radial keratotomy and radial keratectomy or other similar procedures, including laser based procedures, that are performed on the eyes.
16. Meridian therapy (acupuncture), except when used in lieu of an anesthetic.
17. Routine physical examinations, immunizations, use of prophylactic injections including gammaglobulins and flu shots, and the well-child care including immunizations, unless covered by the Optional Wellness Benefit Rider.
18. Charges for treatment, paring or removal of corns, calluses or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending Physician who is treating the Covered Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis, or treatment of the feet by posting or strapping, or range of motion studies, or orthotics.
19. Treatments made in connection with obesity or weight reduction including wiring of the teeth and all forms of intestinal bypass surgery.
20. Charges for services rendered by a Physician, Nurse or other provider if such person: (a) is a Close Relative of the Covered Person's or (b) lives in the same household as the Covered Person, or (c) is the Employer of the Covered Person, except for charges rendered while a Hospital Inpatient.
21. Charges incurred as the result of attempted suicide or intentionally self-inflicted Bodily Injury or Sickness while sane or insane.
22. Treatment for Mental, Nervous or Chemical Dependency Disorders, except as limited in Section IV – Covered Expenses.
23. Charges related to or in connection with: (a) procedures to restore or enhance fertility; and (b) reversal of sterilization; (c) penile implants; and (d) fertility and sterility studies.
24. Hospital and Physician charges for weekend Hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day.
25. Congenital conditions, except with respect to children covered from birth.
26. Sexual reassignments or sexual dysfunctions or inadequacies.
27. Custodial Care, regardless of whom prescribes or renders such care.
28. Services or supplies for which no charge is made or for which the Covered Person is not required to pay.
29. Services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or for pleasure not to exceed 90 days, provided the procedure or treatment is approved for use in the United States.
30. Charges related to or in connection with Human Organ or Tissue Transplants or high dose chemotherapy administered in connection therewith except if provided under Section IV – Covered Expenses.

Section VII – Exclusions and Limitations (Continued)

31. Charges related to Outpatient prescription drugs, except if the Outpatient Prescription Medication Card Benefit Rider is shown in the Schedule of Benefits.
32. Any education or training materials including, but not limited to: pain management; the management of asthma, heart disorders and other medical disorders; pre-natal screening education, unless such programs or materials are offered through Our Health Care Coordination in conjunction with a disease management program.
33. Equipment, other than Durable Medical Equipment, including, but not limited to: modifications to motor vehicles or homes such as to wheelchair lifts or ramps; water therapy device, such as whirlpools or hot tubs; and exercise equipment.
34. Any service or supply to eliminate or reduce a dependency or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism or goal oriented behavioral modification.
35. Any surgical removal of an organ or tissue unless Medically Necessary.
36. Treatment for Home Health Care Services, except as provided in Section IV – Covered Expenses.
37. Treatment for Hospice Care Services, except as limited in Section IV – Covered Expenses.
38. Non-Surgical Back Treatment, except as limited in Section IV – Covered Expenses.
39. Any service or supply in connection with the implant of an artificial organ, including the implant of an artificial organ.
40. Personal convenience services or supplies including without limitation: beauty or barber services; radio and television; non therapeutic massages; telephone charges; take home supplies and guest meals; and motel accommodations.
41. Any non-prescriptive medication.
42. Charges for voice training for a lisp.
43. Breast reduction surgery unless such surgery was performed as part of a mastectomy due to breast cancer.

Section VIII - Cancellation, Termination and Renewal

1. Companion Life may cancel this Policy at any time, after the first policy anniversary, by written notice delivered to the Employer, stating when, not less than thirty-one (31) days thereafter, the cancellation shall take effect. The Employer may cancel this Policy at any time by written notice to Companion Life, with the cancellation to be effective on the later of: (1) Companion Life's receipt of the notice; or (2) the date specified in the notice. Cancellation shall be without prejudice to any Claim originating prior to the Effective Date of cancellation
2. This Policy will be renewed on a year-to-year basis unless canceled pursuant to the above paragraph or unless terminated pursuant to the following paragraphs of this Section.
3. Termination of a Covered Employee's Coverage. A Covered's Employee's coverage will automatically terminate at 12:01 a.m.:
 - a. on the date this Policy terminates;
 - b. on the last day of the first month that the Covered Employee fails to continue to meet any of the applicable eligibility requirements;
 - c. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause section); or
 - d. on the date the Employee's active employment with the Employer ends, except with respect to any continuation mandated pursuant to state or federal law.
4. Termination of a Covered Dependents' Coverage. A Covered's Dependent's coverage will automatically terminate at 12:01 a.m.:
 - a. on the date this Policy terminates;
 - b. on the date the Covered Employee's coverage terminates for any reason;
 - c. on the last date of the month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee);
 - d. on the date specified by the Employer that the Covered Dependent's coverage is terminated by the Employer for cause; or
 - e. on the dated specified by the Employer that the Covered Dependent's coverage terminated.
5. Termination of an Individual's Coverage for Cause. In the event any of the following occurs, the Employer may terminate an individual's coverage for cause:
 - a. fraud, intentional misrepresentation of material fact, or omission in applying for coverage of benefits;
 - b. the knowing misrepresentation, omission, or the giving of false information on the Application for Group Insurance/Membership, Member Status Change Request Form, or other forms completed, by or on behalf of the Covered Plan Participant;
 - c. misuse of the Identification Card.
6. Notice of Termination to Covered Plan Participants – It is the Employer's responsibility to immediately notify Covered Plan Participants of termination of this Policy for any reason.

Section VIII - Cancellation, Termination and Renewal (Continued)

7. Certification of Creditable Coverage – In the event coverage terminates for any reason, a written Certification of Creditable Coverage to the Covered Plan Participant will be issued. The Certification of Coverage will indicate the period of time the Covered Plan Participant was covered under this Policy. Creditable Coverage may reduce the length of any Pre-existing condition exclusion period by the length of time the Covered Plan Participant had prior Creditable Coverage.

Covered Plan Participants may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if coverage under this Policy meets the qualifying creditable coverage guidelines (e.g., no more than a 63-day break in coverage).

Section IX - Continuation Coverage

Any employee insured in this state under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for a least six months under this Contract, or this and its immediately preceding health insurance contract, you may elect to continue group health coverage for yourself and your enrolled family members for the rest of the month of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently.

Cost – These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the company's Group Health Benefit Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- your employment is terminated for cause; or
- your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- your health plan enrollment is terminated and replaced without interruption by another group contract; or
- health insurance is terminated for the entire class of Employees to which you belong; or
- the Group terminates health insurance for all Employees.

Termination of Benefits – Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other group insurance or Medicare.

Conversion – Conversion rights during the continuation period are the same as for insured Employees. If the Group terminates its health insurance Contract during an Employee's continuation period, the Plan Administrator must notify continuing Employees that conversion rights must be exercised within 31 days.

Section X – Continuing Coverage Under Cobra

If you or your Eligible Dependents lose health coverage under the Master Group Policy as a result of a Qualifying Event, you may be entitled to extend coverage for a period of time under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, Domestic Partners and Eligible Dependents of Domestic Partners do not qualify for COBRA coverage.

Qualifying Events – COBRA continuation coverage may be elected if coverage under this Group Health Policy ends due to one or more of the following “Qualifying Events”:

- Your employment ends (except for termination due to gross misconduct or fraud); or
- Your work hours are reduced; or
- You become entitled to Medicare benefits; or
- Your death; or
- Divorce or legal separation; or
- Loss of dependent eligibility; or
- If You are a covered retiree, filing a proceeding in bankruptcy under Title 11 of the United States Code.

If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree’s death.

Continuation Period – Coverage may be continued under COBRA for up to the maximum period of time specified below. The length of time depends on the Qualifying Event(s) and circumstances.

18-Month Continuation Period. If You lose coverage due to termination of Your employment for any reason (other than gross misconduct), or due to reduced work hours, You may continue coverage for Yourself and Your Eligible Dependents for up to eighteen (18) months following the termination or work reduction date.

29-Month Continuation Period. If the Social Security Administration (SSA) determines that You are disabled at any time during the first sixty (60) days of continued coverage, and the Qualifying Event for continued coverage was termination of employment or a reduction in work hours, You may extend COBRA coverage by an additional eleven (11) months, for a total of twenty-nine (29) months of coverage subject to the certain conditions:

- You must notify the Policyholder’s plan administrator of the disability within sixty (60) days of the SSA determination and before the end of the original eighteen (18) month COBRA continuation period; and
- You must agree to pay any increase in the required payment necessary to continue the coverage for the additional eleven (11) months.
- If You have any non-disabled Covered Dependents entitled to COBRA, they are also entitled to extend COBRA coverage by an additional eleven (11) months of coverage.

Section X – Continuing Coverage Under Cobra (Continued)

36-Month Continuation Period. Coverage may be continued for up to thirty-six (36) months from the date of coverage would have stopped due to a Qualified Event other than described above.

If a second Qualifying Event occurs within the original eighteen (18) month continuation period, coverage may be continued for a total of thirty-six (36) months from the date of the first Qualifying Event. Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Notification Requirements – You must notify Your Human Resources or Employee Benefits office in writing within sixty (60) days when either of the following Qualifying Events occur:

- Divorce or legal separation
- A child loses eligibility as a dependent

Your Human Resources or Employee Benefits office will send You the appropriate forms within fourteen (14) days after receiving Your notice.

Election Period – You have at least sixty (60) days to elect to continue coverage under COBRA. The election period ends on the later of:

- Sixty (60) days after the date coverage would have stopped due to a Qualifying Event; or
- Sixty (60) days after the date You receive notice of COBRA continuation rights.

Unless otherwise specified, You or Your spouse's election to continue will be considered an election on behalf of all other Covered Dependents who would also lose coverage because of the same Qualifying Event.

Required Payment – You are required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost charged for Employees with similar coverage, including both the portion paid by Employees and any portion paid by the Employer before the qualifying event, plus 2 percent for administrative costs.

If You are receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the Plan's total cost of coverage.

You have forty-five (45) days from the date of election to make the first required payment for COBRA continuation coverage. Payment must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum thirty (30) day grace period for payments. Payment is considered to be made on the date it is sent to the Plan.

Section X – Continuing Coverage Under Cobra (Continued)

Continued Coverage Ends – Continuation of coverage under COBRA will end for You or Your Eligible Dependents on the earliest of the following dates:

- The date Your maximum COBRA period ends.
- The date You fail to make the required payment for continued coverage within the thirty (30) day grace period.
- The date You become covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to You, You may continue COBRA coverage only until these limitations cease.
- For a spouse or dependent who was entitled to Medicare prior to a Qualifying Event due to termination of employment or reduction of work hours, eighteen (18) months after the Qualifying Event, or if later, thirty-Six (36) months from the date You become entitled to Medicare.
- The date the Master Group Policy terminates.

Section XI – Conversion Privilege

Eligibility Criteria for Conversion

A Covered Plan Participant may apply for an individual policy (hereinafter referred to as a “converted policy”) if:

1. the Covered Plan Participant was continuously covered for at least three months under this Policy and/or under another group policy, in effect, immediately prior to this Policy providing similar benefits; and
2. the Covered Plan Participant’s coverage has been terminated for any reason, including discontinuance of this Policy in its entirety and termination of continued coverage under COBRA.

Companion Life will mail to a Covered Plan Participant, within 14 days after the Covered Plan Participant gives proper notice to Companion Life that he/she is considering applying for a converted policy of the Covered Plan Participant requests such information, a converted policy application and premium notice, including and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

Companion Life must receive a completed application for a converted policy and the applicable Premium payment within the 63-day period beginning on the date the coverage under this Policy terminated. If coverage has been terminated due to the non-payment of employee contribution by the Employer, Companion Life must receive the completed converted policy application and the applicable Premium payment within the 63-day period beginning on the date notice was given that the coverage terminated.

In the event Companion Life does not receive the converted policy application and the initial Premium payment with such 63-day period, the Covered Plan Participant’s converted policy application will be denied and the Covered Plan Participant will not be entitled to a converted policy.

Additionally, a Covered Plan Participant is not entitled to a converted policy if:

1. the Covered Plan Participant is eligible for or covered under the Medicare program;
2. the Covered Plan Participant’s coverage terminated because the Covered Employee failed to make any Premium contribution payment on a timely basis;
3. coverage was replaced by any group policy, contract, plan, or program, including self-insured plan or program, that provides benefits similar to the benefits provided under this Group Health Plan Description; or
4. a. the Covered Plan Participant is covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits similar to the benefits provided under this Policy; or
b. the Covered Plan Participant is eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Policy; or

Section XI – Conversion Privilege (Continued)

- c. benefits similar to the benefits provided under this Policy are provided for or are available to the Covered Plan Participant pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and
- 5. the benefits provided under the sources referred to in paragraph 4a. and c. above, together with the benefits provided by Companion Life’s converted policy would result in over insurance in accordance with Companion Life’s over insurance standards, as determined by Companion Life.

Neither the Employer nor Companion Life has any obligation to notify any Covered Plan Participant of this conversion privilege when the Covered Plan Participant’s coverage terminates or at any other time. It is the sole responsibility of the Covered Plan Participant to exercise this conversion privilege by submitting a Companion Life converted policy application and the initial Premium payment to Companion Life on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day the individual’s coverage hereunder terminated.

Note: Companion Life’s converted policies are not a continuation of coverage under COBRA or any other state’s similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Policy. A Covered Plan Participant applying for a Companion Life converted policy has two options:

- 1) a converted policy providing major medical coverage, and
- 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan. In any event, Companion Life shall not be required to issue a converted policy unless required to do so by applicable state law.

Section XII – Extension of Benefits

In the event this Policy is terminated, there is no coverage for any Health Care Service rendered on or after the termination date. The extension of benefits provision set forth below only apply when this Policy is terminated. The extension of benefits provided hereunder do not apply when an individual Covered Plan Participant's terminates as long as this Policy remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is the Covered Plan Participant's responsibility to provide acceptable documentation to Companion Life that the Covered Plan Participant is entitled to an extension of benefits.

1. In the event a Covered Plan Participant is Totally Disabled on the termination date of this Policy as a result of a specific Accident or illness incurred while the Covered Plan Participant was covered under this Policy, Companion Life will provide a limited extension of benefits for the disabled Covered Plan Participant only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted, however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of this Policy.

For purposes of this section, a person is "Totally Disabled" only if, in the opinion of Companion Life, the Covered Plan Participant is unable to work at any gainful job for which the Covered Plan Participant is suited by education, training, or experience. For those Covered Plan Participants who do not work (e.g., a student, child, or non-working spouse) such Covered Plan Participant is Totally Disabled only if in the opinion of Companion Life, the Covered Plan Participant is unable to perform those normal day-to-day activities which they would otherwise perform and such Covered Plan Participant requires regular care and attendance by a Physician.

2. In the event a Covered Plan Participant is receiving covered dental treatment as of the termination date of this Policy, Companion Life will provide a limited extension of benefits for such covered dental treatment provided:
 - a. a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while the Covered Plan Participant was covered under this Policy;
 - b. the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and

Section XII – Extension of Benefits (Continued)

- c. the dental procedures were performed within 90 days after the Covered Plan Participant's coverage terminated under this Policy, and the termination did not occur as a result of the Covered Employee's voluntary termination of coverage.

This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of this Policy or on the date the Covered Plan Participant becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or services for similar dental procedures. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

2. In the event a Covered Plan Participant is pregnant as of the termination date of this Group Health Plan, Companion Life will provide a limited extension of the maternity expense benefits provided by this Policy, provided the pregnancy commenced while the pregnant Covered Plan Participant was covered under this Policy, as determined by Companion Life. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

Section XIII – Claims Processing

Introduction

This section is intended to:

1. help the Covered Plan Participant understand what the Covered Plan Participant or the Covered Plan Participant's treating Providers must do, under the terms of this Policy, in order to obtain payment for expenses for Covered Services they have rendered or will render to the Covered Plan Participant;
2. provide the Covered Plan Participant with a general description of the applicable procedures that will be used for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the Covered Plan Participant when benefits are denied.

Under no circumstances will Companion Life be held responsible for, nor will Companion Life accept liability relating to, the failure of the Covered Plan Participant's Group Health Plan's sponsor or plan administrator to: 1) comply with any applicable disclosure requirements; 2) provide the Covered Plan Participant with a Summary Plan Description (SPD); or 3) comply with any other legal requirements. Covered Plan Participant should contact the plan sponsor or administrator with questions relating to the Group Plan's SPD. Companion Life is not the Covered Plan Participant's Group Health Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims - For the purpose of this Policy, there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that the Covered Plan Participant become familiar with the types of claims that can be submitted to Companion Life and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to Companion Life. PPO Providers have agreed to file Post-Service Claims for services rendered to a Covered Plan Participant. In the event a Provider who renders services to the Covered Plan Participant does not file a Post-Service Claims for such services, it is the Covered Plan Participant's responsibility to file it with Companion Life.

Companion Life must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if Companion Life does not receive it at the address indicated on the Covered Plan Participant's ID Card within one year of the date the service was rendered unless the Covered Plan Participant was legally incapacitated.

Section XIII – Claims Processing (Continued)

For a Post-Service Claim, Companion must receive an itemized statement from the health care Provider for the service rendered along with a completed claim form. The itemized statement must contain the following information:

1. the date the service was provided;
2. a description of the service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis codes(s);
5. the Provider's name and address;
6. the name of the individual who received the service; and
7. the Covered Employee's name and contract number as they appear on the ID Card.

The itemized statement and claim form must be received by Companion Life at the address indicated on the Covered Plan Participant's ID Card.

The Processing of Post-Service Claims

Companion Life will use its best efforts to pay, contest, or deny all Post-Service Claims for which Companion Life has all of the necessary information, as determined by Companion Life. Post-Service Claims will be paid, contested, or denied within the timeframes described below:

- **Payment for Post-Service Claims**

When payment is due under the terms of the Policy, Companion Life will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, Companion Life will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 45 days of receipt. The Covered Plan Participant may receive notice of payment for paper claims within 30 days of receipt. If Companion Life is unable to determine whether the claim or a portion of the claim is payable because more or additional information is needed, Companion Life may contest the claim within the timeframes set forth below.

- **Contested Post-Service Claims**

In the event Companion Life contests an electronically submitted Post-Service Claim, or a portion of such claim, Companion Life will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event Companion Life contests a Post-Service Claim submitted on a paper form, or a portion of such claim, Companion Life will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that

Section XIII – Claims Processing (Continued)

Companion Life reasonably expects to notify the Covered Plan Participant of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If Companion Life requests additional information, Companion Life must receive it within 45 days of the request for the information. If Companion Life does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of Companion Life at the time and may be denied. Upon receipt of the requested information, Companion Life will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- **Denial of Post-Service Claims**

In the event Companion Life denies a Post-Service Claims submitted electronically, Companion Life will use its best effort to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event Companion Life denies a paper Post-Service Claim, Companion will use its best effort to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Plan Participant's responsibility to ensure that Companion Life receives all information determined by Companion Life as necessary to adjudicate a Post-Service Claim. If Companion Life does not receive the necessary information, the claim or a portion of the claim may be denied.

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Determination standards and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

In the event, Companion Life will use its best effort to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by Companion Life or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by Companion Life within the applicable timeframe is subject to the payment of simple interest at the rate established by applicable Insurance Code.

Companion Life will investigate any allegation of improper billing by a Provider upon receipt of written notification from the Covered Plan Participant. If Companion Life determines that the Covered Plan Participant was billed for a service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due to solely to the notification from the Covered Plan Participant, Companion Life will pay the Covered Plan Participant 20 percent of the amount of the amount of the reduction, up to a total of \$500.

Pre-Service Claims

How to File A Pre-Service Claim

This Policy may condition coverage, benefits, or payment (in whole or in part), of a specific Covered Service, on the receipt by Companion Life of a Pre-Service Claim as that term is defined herein. In order to determine

Section XIII – Claims Processing (Continued)

whether Companion Life must receive a Pre-Service Claim for a particular Covered Service, please refer to the Covered Services section and other applicable sections of this Policy. The Covered Plan Participant may also call Companion Life's customer service number on the Covered Plan Participant's ID card for assistance.

Companion Life is not required to render an opinion or make a coverage or benefit determination with respect to a service that has not actually been provided to the Covered Plan Participant unless the terms of this Policy require (or condition payment upon) approval by Companion Life for the service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, Companion Life will use its best effort to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, Companion Life will use its best effort to provide notice within 24 hours of: 1) the need for additional information; 2) the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) the date that Companion Life reasonably expects to provide notice of the decision. If Companion Life requests additional information, Companion Life must receive it within 48 hours of the request. Companion Life will use its best effort to provide notice of the decision on an Covered Plan Participant's Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period that was afforded to provide the specific additional information as described above.

Benefit Determinations on Pre-Service Claims That Do Not Involve Urgent Care

Companion Life will use its best efforts to provide notice of the decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. Companion Life may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, Companion Life will use its best effort to provide notice of the extension and reasons for it. Companion Life will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service claims within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by Companion Life.

If additional information is necessary to make a determination, Companion Life will use its best effort to: provide notice of the need for additional information prior to the expiration of the initial 15-day period; 2) identify the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) inform the Covered Plan Participant of the date that Companion Life reasonably expects to notify the Covered Plan Participant of the decision. If Companion Life requests additional information, Companion Life must receive it within 45 days of the request for the information. Companion Life will use its best effort to provide notification of the decision on an Covered Plan Participant's Pre-Service Claim within 15 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Determination standards and appeal procedures described in this section.

Section XIII – Claims Processing (Continued)

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for services will be considered an Adverse Benefit Determination when:

- Companion Life and/or the Employer has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of services; and
- the reduction or termination of coverage or benefits by Companion Life and/or the Employer was not due to an amendment of this Policy or termination of the Covered Plan Participant's coverage as provided by this Policy.

Companion Life will use its best efforts to notify the Covered Plan Participant of such reduction or termination in advance so that the Covered Plan Participant will have a reasonable amount of time to have the reduction or termination renewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event will Companion Life be required to provide more than a reasonable period of time within which the Covered Plan Participant may develop the appeal before Companion Life actually terminates or reduces coverage for the services.

Requests for Extension of Services

The Covered Plan Participant's Provider may request an extension of coverage or benefits for a service beyond the approved period of time or number of approved services. If the request for an extension is for a Claim Involving Urgent Care, Companion Life will use its best efforts to notify the Covered Plan Participant of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. Companion Life will use its best efforts to notify the Covered Plan Participant within 24 hours if: 1) additional information is needed; 2) the Covered Plan Participant or the Covered Plan Participant's representative failed to follow proper procedures in the request for an extension. If Companion Life and/or the Employer request additional information, the Covered Plan Participant will have 48 hours to provide the requested information. Companion Life may notify the Covered Plan Participant orally or in writing, unless the Covered Plan Participant or the Covered Plan Participant's representative specifically request that it be in writing. A denial of a request for extension of services is considered an Adverse Benefit Determination and is subject to the Adverse Determination review procedure below.

Section XIII – Claims Processing (Continued)

Standards For Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

Companion Life will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to the Covered Plan Participant free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Policy provisions which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If Covered Plan Participant's claim is a Claim Involving Urgent Care, Companion Life may notify the Covered Plan Participant orally within the proper timeframes, provided Companion Life follows-up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

How to Appeal an Adverse Benefit Determination

The Covered Plan Participant, or a representative designated by the Covered Plan Participant in writing, has the right to appeal an Adverse Benefit Determination. Companion Life will review the Covered Plan Participant's appeal through the review process described below. The Covered Plan Participant's appeal must be submitted in writing to Companion Life within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Covered Plan Participant to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations.

- Companion Life must receive the Covered Plan Participant's appeal of an Adverse Benefit Determination in person or in writing;
- The Covered Plan Participant may request to review pertinent documents, such as any internal rule guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, the Covered Plan Participant may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Policy to the Covered Plan Participant's medical circumstances.

Section XIII – Claims Processing (Continued)

- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
- Companion Life may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews an Covered Plan Participant's Adverse Benefit Determination on behalf of Companion Life will be identified upon request; and
- If Covered Plan Participant's claim is a Claim Involving Urgent Care, the Covered Plan Participant may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between the Covered Plan Participant and Companion Life by telephone, facsimile or other available expeditious method.

Timing of Appeal Review on Adverse Benefit Determinations by Companion Life

Companion will use its best efforts to review a Covered Plan Participant's appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims – within 30 days of the receipt of the Covered Plan Participant's appeal; or
- Post-Service Claims - within 50 days of the receipt of the Covered Plan Participant's appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care services made within 24 hours prior to the termination of the services) – within 72 hours of receipt of the Covered Plan Participant's request. If additional information is necessary Companion Life notify the Covered Plan Participant within 24 hours and Companion Life must receive the requested information with 48 hours of the request. After Companion Life receives the additional information, Companion Life will have an additional 48 hours to make a final determination.

Note: The nature of a claim for services (i.e., whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the service was initially reviewed or provided.

The Covered Plan Participant, or a Provider acting on behalf of the Covered Plan Participant, who has a claim denied as not Medically Necessary has the opportunity to appeal the claim denial. The appeal may be directed to an employee of Companion Life who is a licensed Physician responsible for Medical Necessity reviews. The appeal may be by telephone and the Physician will respond to the Covered Plan Participant, within a reasonable time, not to exceed 15 business days.

Submit Appeals of Adverse Benefit Determinations to:

[Director of Claims
Companion Life Insurance Company
Post office Box 100102
Columbia, South Carolina 29202-3102
Fax (800) 836-5433]

Section XIII – Claims Processing (Continued)

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

In order to process claims, Companion Life and/or the Employer may need certain information, including information regarding other health care coverage the Covered Plan Participant may have. The Covered Plan Participant must cooperate with the Employer and/or Companion Life's effort to obtain such information by, among other ways, signing any release of information form at the request of Companion Life. Failure by the Covered Plan Participant to fully cooperate with Companion Life and/or the Employer may result in a denial of the pending claim.

2. Physical Examination:

In order to make coverage and benefit decisions, the Employer may, at its expense, require the Covered Plan Participant to be examined by a health care Provider of the Employer's choice as often as is reasonably necessary while a claim is pending. Failure by the Covered Plan Participant to fully cooperate with such examination shall result in a denial of the pending claim.

3. Legal Actions:

No legal action arising out of or in connection with coverage under this Policy may be brought against the Employer within the 60-day period following receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

Companion Life relies on information provided on the itemized statement and the claim form when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy Companion Life and/or the Employer may have, in denial of the claim or cancellation of rescission of the Covered Plan Participant's coverage.

5. Explanation of Benefits Form:

All claims decisions, including denial and claims review decisions, will be communicated to the Covered Plan Participant in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

- a. the specific reason or reasons for the Adverse Benefit Determination;
- b. reference to the specific Policy provisions which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

Section XIII – Claims Processing (Continued)

- c. a description of any additional information that would change the initial determination and why that information is necessary;
- d. a description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- e. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond the Control of Companion Life:

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of Companion Life, results in facilities, personnel or financial resources of Companion Life being unable to process claims for Covered Services, Companion Life will have no liability or obligation for any delay in the payment of claims for Covered Services, except that Companion Life will make a good faith effort to make payment for such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of Companion Life if Companion Life cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section XIV - Subrogation

In the event payment is made under this Policy to or on behalf of a Covered Plan Participant for any claim in connection with or arising from a Condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, the Employer and/or this Policy, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery such Covered Plan Participant has against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. Companion Life on behalf of the Employer and/or this Policy, and the Employer, shall have the right to subrogate out of any recovery or settlement the Participant is able to obtain including, but not limited to uninsured motorists, even if the Covered Plan Participant is not made whole for his/her losses. Companion Life may recover, on behalf of the Employer and/or this Policy, the amount of any payments made on the Covered Plan Participant's behalf minus Companion Life or the Employer's pro rata share for any costs and attorney fees incurred by the Covered Plan Participant in pursuing and recovering damages. Companion Life may subrogate, on behalf of the Employer and/or this Policy, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although the Employer may, but is not required to, take into consideration any special factors relating to the Covered Plan Participant's specific case in resolving the subrogation claim, the Employer will have the first of recovery or settlement amount the Covered Plan Participant is able to obtain even if the Covered Plan Participant or Covered Plan Participant's attorney believes that the Covered Plan Participant has not been made whole for his/her losses or damages by the amount of the recovery or settlement.

The Covered Plan Participant shall promptly execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigations as may be requested by Companion Life, and shall do whatever is necessary to enable Companion Life to exercise the Employer's subrogation rights and shall do nothing to prejudice such rights. Additionally, the Covered Plan Participant or the Covered Plan Participant's legal representative shall promptly notify Companion Life in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to Companion Life any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgment proceeds without the Employer's prior written consent. No waiver, release of liability, or other documents executed by a Covered Plan Participant without such notice to Companion Life shall be binding upon the Employer.

If the director or his designee, upon being petitioned by the Covered Plan Participant, determines that the exercise of subrogation by an insurer is inequitable and commits an injustice to the insured, subrogation is not allowed. Attorneys' fees and costs must be paid by the insurer from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law in accordance with Section 38-3-210.

Section XV – The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When a Covered Plan Participant becomes covered under Medicare and continues to be eligible and covered under the terms of this Group Health Plan Description, coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, coverage hereunder shall be secondary to any Medicare benefits. To the extent this Policy is primary, claims for Covered Services should be filed with Companion Life first.

Under Medicare, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such Covered Plan Participant. Also, the Employer may not induce such Covered Plan Participant to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

A Covered Plan Participant who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease (“ESRD”) must notify his/her Employer.

Individuals With End Stage Renal Disease

For a Covered Plan Participant who is entitled to Medicare coverage because of ESRD, group health coverage will be provided on a primary basis for 30 months beginning with the earlier of:

1. the month in which the individual became entitled to Medicare Part A ESRD benefits; or
2. the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retires and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health coverage will remain primary for the ESRD coordination period. For individual eligible for Medicare due to ESRD, group health coverage will be provided, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

This Policy will provide primary coverage to Covered Plan Participants if:

1. the Employer is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. the Covered Plan Participants are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage under the Policy is subject to the following terms:

1. For an enrolled individual, group health insurance coverage will be provided, as set forth herein, on a primary basis during any month in which that individual meets the description set out in the above paragraphs.

Section XV – The Effect of Medicare Coverage/Medicare Secondary Payer Provisions (Continued)

2. Individual entitlement to primary coverage under this sub-section will terminate automatically when:
 - a. the individual turns 65 years of age; or
 - b. the individual no longer qualifies for Medicare coverage because of disability; or
 - c. the individual elects Medicare as the primary payer. Coverage will terminate as of the date of such election.
3. Entitlement of the Covered Employee and/or his or her Covered Dependents to primary coverage under this sub-section will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. The Employer shall notify Companion Life, without delay, of any such change in status.

Miscellaneous

This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Policy.

Companion Life shall not be liable to the Employer or to any individual covered under this Policy on account of any nonpayment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this section.

Section XVI - Coordination of Benefits

Applicability

1. This Coordination of Benefit ("COB") provision applies to This plan when an Insured or the Insured's covered Dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in the Section entitled "Effect on the Benefits of This Plan."

Definitions

1. A. "PLAN" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Group insurance coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
 - b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

3. "THIS PLAN" is the part of the Policy that provides benefits for medical care expenses.
4. "PRIMARY PLAN"/"SECONDARY PLAN." The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.
5. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

6. "ALLOWABLE EXPENSE" means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made

Section XVI - Coordination of Benefits (Continued)

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

NOTE: When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

7. "CLAIM DETERMINATION PERIOD" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1. GENERAL - When there is a basis for a claim under This Plan and another plan, This Plan is a secondary plan which has its benefits determined after those of the other plan, unless:
 - a. the other plan has rules coordinating its benefits with those of This Plan; and
 - b. both those rules and This Plan's rules, in paragraph 2 below, require that This Plan's benefits be determined before those of the other plan.

2. RULES - This Plan determines its order of benefits using the first of the following rules which applies:
 - a. Non-Dependent/Dependent - The benefits of the Plan which covers the person as an Insured or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
 - b. Dependent Child/Parents Not Separated or Divorced - Except as stated in subparagraph 3. a. below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents":
 - 1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in 2) immediately above, instead it has a rule based upon the gender of the parents, and if, as a result, the plans do not agree on the order of benefits, then the rule in the other plan will decide the order of benefits.

- c. Dependent Child/Separated or Divorced Parents - Two or more plans may cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1) first, the plan of the parent with custody of the child;
 - 2) then, the plan of the spouse of the parent with the custody of the child; and
 - 3) finally, the plan of the parent not having custody of the child.

Section XVI - Coordination of Benefits (Continued)

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2. b. above.
- e. Active/Inactive Employee - The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - a. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Effect on the Benefits of This Plan

1. When This Section Applies. This Section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in 2. immediately below.
2. REDUCTION IN THIS PLAN'S BENEFITS - The benefits of This Plan will be reduced when the sum of:
 - a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - b. the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Section XVI - Coordination of Benefits (Continued)

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by Us is more than the amount We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.



COMPANION LIFE INSURANCE COMPANY
 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
 P.O. Box 100102, Columbia, South Carolina 29202-3102
 (803) 735-1251

APPLICATION FOR HIGH DEDUCTIBLE HEALTH PLAN

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant.) _____ (Product Name).

Name of Applicant: _____
 (Company Correct Legal Name)

Address of Applicant: _____
 (Physical)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the _____ day of _____, _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Application and Companion Life Insurance Company.

Health Savings Account: Do you currently have a Health Savings Account Administrator? Yes No

Is it a requirement that eligible employees participate in the HSA through your HSA Administrator? Yes N

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week at least 48 weeks a year for the Applicant. To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor other than substance abuse or chemical dependency; and 2) be performing the normal duties of his or her occupation at one of the Employer's normal places of business or at a location to which the Employee must travel to do his or her job. An Employee must begin work before he or she is considered Actively-at-work. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month that the requirement is met.

Periods of Continuous Employment as Prerequisite to Eligibility: Coverage for new Employees hired following the Effective Date of the Contract will begin on the first monthly Effective Date following _____ days of employment.

PARTICIPATION Requirements:

1. When the Employer pays 100% of the single coverage premium, all eligible Employees must enroll with at least single coverage.
2. When the Employer pays less than 100% of the single coverage premium:

Employee may elect not to receive coverage:
 The number of Employees not electing coverage is determined by group size.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period for the enrollment, Whichever is earlier.

Late Enrollee: An eligible Employee or Dependent who enrolls under this Contract other than during:

1. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. A Special Enrollment period.

Late Enrollees will be excluded from coverage for 12 months then have a 6-month Pre-existing Condition Limitation.

Special Enrollment: If the Enrollment is eligible and not already enrolled, or if a Dependent is eligible and not already enrolled, Companion Life will allow the Employee or Dependent to enroll if each of the following is met:

1. The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
2. The Employee stated in writing at the time that coverage under a Group Health Plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
3. The Employee's or Dependent's coverage described in paragraph 1 above:
 - a. Was under a COBRA or state continuation provision and the coverage under the provision was exhausted; or
 - b. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment;
 - c. Was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
4. The Employee requests the enrollment not later than 31 days after the date prior coverage ended due to loss of eligibility or Employer contribution stopped as described above.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage. However, the Employee and Employee's spouse may be subject to the Pre-existing Condition Limitation period up to 12 months. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than a newborn, adopted child or child placed for adoption may be subject to the Pre-existing Condition Limitation period up to 12 months.

PRE-EXISTING CONDITION LIMITATIONS

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Enrollment Date.

The Pre-existing Condition Exclusion lasts until the earlier of:

- a. The member has not received medical care, treatment, or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends sometime after the Effective Date of coverage; or
- b. 12 months after the Enrollment Date.

In the case of a Late Enrollee, the Pre-existing Condition Exclusion begins on the Enrollment Date and lasts for 18 months.

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or eligible dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

Companion Life shall count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

The Pre-existing Condition Limitations do not apply to Routine Maternity Care or to Generic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with the Employee or Employee's spouse for the purpose of adoption before he or she reaches 18 years of age if the Employee applied for coverage and the premium was paid within 31 days from the birth, adoption or placement for adoption. If, however, the Employee or Dependent does not have Creditable Coverage after the end of the first 63-day period, the above newborn and adopted provisions do not apply.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitation apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Creditable Coverage: Benefits or coverage provided under:

1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Services or a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulation;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. Excepted Benefits is defined in the Contract.

Companion Life will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

The period of any Pre-existing Condition exclusion is reduced or eliminated by the total periods of Creditable Coverage listed above.

It is understood and agreed that the Applicant shall pay Companion Life, in advance, the premium specified in the Master Contract on behalf of the Applicant's Employee's who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Companion Life and the Applicant. Coverage is not effective unless and until approved by the Underwriting Department at Companion Life's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from the policyholder's funds or funds contributed by the insured person, or from both.

The Applicant hereby expressly acknowledges that it understands that this application constitutes a Contract solely between the Applicant and Companion Life.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Companion Life and that no person, entity or organization other than Companion Life shall be held accountable or liable to the Applicant for any of Companion Life's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Companion Life other than those obligations created under other provisions of this Contract.

Dated at (City) _____, [South Carolina], this _____, day of _____, _____

Name of Application (Company Name)

By: _____
(Authorized Signature)

(Signature of Agent/Broker)



7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
(803) 735-1251

HIGH DEDUCTIBLE HEALTH PLAN ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI) _____	2. Birthdate ____/____/____	3. Male <input type="checkbox"/> Female <input type="checkbox"/>
4. Address: (Street) _____ (City) _____ (State) _____ (Zip) _____		
5. Employee Social Security Number ____ - ____ - _____		6. Home Phone (____) _____ - _____ Email: _____
7. Name of Employer: _____		8. Group No.: _____
9. Dept. No.: _____		10. Effective Date of Action Requested: ____/____/____

REASON FOR APPLICATION

11. New Member – I am a full-time employee working at least 30 hours per week, 48 weeks per year? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Full-time Date of Hire: ____/____/____	
Coverage Change – Reason for Change: _____ Date of Occurrence: _____	
Late Enrollee Address Change Beneficiary Change Cancellation – Date Left Employment: ____/____/____	
Reinstatement – Reason: Return from Layoff Return from Leave Cancellation Error	
COBRA – Qualifying Event: _____ Start Date: ____/____/____	
State Continuation – State Date: ____/____/____	
Sponsored Membership – Sponsored Member's Social Security Number: ____ - ____ - _____	

COVERAGE INFORMATION

12. Check One: PPO <input type="checkbox"/> NON-PPO <input type="checkbox"/> TYPE OF GROUP COVERAGE: Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/>	
No Medical Coverage due to (Check One): Covered by Military <input type="checkbox"/> Insurance with Another Company <input type="checkbox"/> Covered by Medicare <input type="checkbox"/>	
Covered by Spouse with this Employer <input type="checkbox"/> Other (explain): _____	

ENROLLMENT INFORMATION (List all individuals to be covered – use additional sheet if necessary.)

15.	Last Name	First Name	Birth date (mm/dd/yyyy)	Male or Female	Social Security Number	Full-Time Student*
Spouse						Yes <input type="checkbox"/> No <input type="checkbox"/>
Child					N/A	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child					N/A	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child					N/A	Yes <input type="checkbox"/> No <input type="checkbox"/>

(*Age 19 through 22 Only) Please attach Registrar's letter or tuition showing credit hours. This is required before coverage can become effective for this dependent.

OTHER COVERAGE INFORMATION

16. Other than your coverage with this employer, do you or any of your family members have other health (including Medicare) coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>

EMPLOYEE CERTIFICATION Authorization to Release Information and Statement of Understanding

I hereby authorize the release of any medical or non-medical information about myself or eligible or enrolled dependents by any insurance company, medical professional, medical institution or other healthcare provider concerning the diagnosis or any health condition, including drug or alcohol abuse. This authorization for release of my (our) past, present and future information, in include Medicare Parts A and B claims, is for eligibility determination for coverage or review or investigation of a claim. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and employer. I also understand that my coverage may be voided or terminated or claims denied if material misstatements or misrepresentations have been made on this application. I certify that all statements made herein are complete and true to the best of my knowledge.

If I do not elect to receive coverage under the group plan offered by my employer and currently do not have other health insurance coverage, I understand that if I wish to enroll later, I will be excluded from coverage for twelve months then subject to pre-existing conditions for six months.

Signature _____ Date _____

FRAUD WARNING NOTICES: (If the Applicant firm is located in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

[Arkansas/Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.
DC	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky/Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico/ Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

SERFF Tracking Number: CMLX-125830219 *State:* Arkansas
Filing Company: Companion Life Insurance Company *State Tracking Number:* 40352
Company Tracking Number: GHSAR0003201F01
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CMLX-125830219 State: Arkansas
 Filing Company: Companion Life Insurance Company State Tracking Number: 40352
 Company Tracking Number: GHSAR0003201F01
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: MMEM02GR08
 Project Name/Number: MMEM02GR08/GHSAR0003201F01

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 09/29/2008
Comments:
Attachment:
 Compliance Certificate (Rule 19).PDF

Satisfied -Name: Application **Review Status:** Approved-Closed 09/29/2008
Comments:
Attachment:
 Application for High Deductible Health Plan.PDF

Satisfied -Name: Readability Certificate **Review Status:** Approved-Closed 09/29/2008
Comments:
Attachment:
 Readability Certificate.PDF

Satisfied -Name: Consumer Information Notice **Review Status:** Approved-Closed 09/29/2008
Comments:
Attachment:
 Consumer Information Notice.PDF

Satisfied -Name: Compliance Certificate (PPO) **Review Status:** Approved-Closed 09/29/2008
Comments:
Attachment:
 Compliance Certificate (PPO).PDF

Review Status:

SERFF Tracking Number: CMLX-125830219 State: Arkansas
Filing Company: Companion Life Insurance Company State Tracking Number: 40352
Company Tracking Number: GHSAR0003201F01
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Satisfied -Name: GHDHP 1010 (08/08) Approved-Closed 09/29/2008
Comments:
Attachment:
GHDHP 1010 (08_08).PDF

SERFF Tracking Number: CMLX-125830219 State: Arkansas
Filing Company: Companion Life Insurance Company State Tracking Number: 40352
Company Tracking Number: GHSAR0003201F01
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: MMEM02GR08
Project Name/Number: MMEM02GR08/GHSAR0003201F01

Satisfied -Name: Application for High Deductible Health Plan
Review Status: Approved-Closed 09/29/2008

Comments:

Attachment:

Application for High Deductible Health Plan.PDF



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

STATE OF ARKANSAS

**COMPLIANCE CERTIFICATION
RULE 19**

Companion Life Insurance Company is aware of Rule 19, entitled Unfair Sex Discrimination In The Sale of Insurance and certifies that the Group Hospital/Surgical form filing submission meets the provisions of said Rule.

A handwritten signature in black ink, appearing to read 'Karl C. Kemmerlin', is written over a horizontal line.

Karl C. Kemmerlin .
Vice President & CFO

Dated: September 23, 2008



COMPANION LIFE INSURANCE COMPANY
 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
 P.O. Box 100102, Columbia, South Carolina 29202-3102
 (803) 735-1251

APPLICATION FOR HIGH DEDUCTIBLE HEALTH PLAN

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant.) _____ (Product Name).

Name of Applicant: _____
 (Company Correct Legal Name)

Address of Applicant: _____
 (Physical)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the _____ day of _____, _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Application and Companion Life Insurance Company.

Health Savings Account: Do you currently have a Health Savings Account Administrator? Yes No

Is it a requirement that eligible employees participate in the HSA through your HSA Administrator? Yes N

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week at least 48 weeks a year for the Applicant. To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor other than substance abuse or chemical dependency; and 2) be performing the normal duties of his or her occupation at one of the Employer’s normal places of business or at a location to which the Employee must travel to do his or her job. An Employee must begin work before he or she is considered Actively-at-work. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month that the requirement is met.

Periods of Continuous Employment as Prerequisite to Eligibility: Coverage for new Employees hired following the Effective Date of the Contract will begin on the first monthly Effective Date following _____ days of employment.

PARTICIPATION Requirements:

1. When the Employer pays 100% of the single coverage premium, all eligible Employees must enroll with at least single coverage.
2. When the Employer pays less than 100% of the single coverage premium:

Employee may elect not to receive coverage:
 The number of Employees not electing coverage is determined by group size.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period for the enrollment, Whichever is earlier.

Late Enrollee: An eligible Employee or Dependent who enrolls under this Contract other than during:

1. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. A Special Enrollment period.

Late Enrollees will be excluded from coverage for 12 months then have a 6-month Pre-existing Condition Limitation.

Special Enrollment: If the Enrollment is eligible and not already enrolled, or if a Dependent is eligible and not already enrolled, Companion Life will allow the Employee or Dependent to enroll if each of the following is met:

1. The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
2. The Employee stated in writing at the time that coverage under a Group Health Plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
3. The Employee's or Dependent's coverage described in paragraph 1 above:
 - a. Was under a COBRA or state continuation provision and the coverage under the provision was exhausted; or
 - b. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment;
 - c. Was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
4. The Employee requests the enrollment not later than 31 days after the date prior coverage ended due to loss of eligibility or Employer contribution stopped as described above.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage. However, the Employee and Employee's spouse may be subject to the Pre-existing Condition Limitation period up to 12 months. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than a newborn, adopted child or child placed for adoption may be subject to the Pre-existing Condition Limitation period up to 12 months.

PRE-EXISTING CONDITION LIMITATIONS

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Enrollment Date.

The Pre-existing Condition Exclusion lasts until the earlier of:

- a. The member has not received medical care, treatment, or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends sometime after the Effective Date of coverage; or
- b. 12 months after the Enrollment Date.

In the case of a Late Enrollee, the Pre-existing Condition Exclusion begins on the Enrollment Date and lasts for 18 months.

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or eligible dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

Companion Life shall count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

The Pre-existing Condition Limitations do not apply to Routine Maternity Care or to Generic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with the Employee or Employee's spouse for the purpose of adoption before he or she reaches 18 years of age if the Employee applied for coverage and the premium was paid within 31 days from the birth, adoption or placement for adoption. If, however, the Employee or Dependent does not have Creditable Coverage after the end of the first 63-day period, the above newborn and adopted provisions do not apply.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitation apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Creditable Coverage: Benefits or coverage provided under:

1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Services or a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulation;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. Excepted Benefits is defined in the Contract.

Companion Life will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

The period of any Pre-existing Condition exclusion is reduced or eliminated by the total periods of Creditable Coverage listed above.

It is understood and agreed that the Applicant shall pay Companion Life, in advance, the premium specified in the Master Contract on behalf of the Applicant's Employee's who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Companion Life and the Applicant. Coverage is not effective unless and until approved by the Underwriting Department at Companion Life's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from the policyholder's funds or funds contributed by the insured person, or from both.

The Applicant hereby expressly acknowledges that it understands that this application constitutes a Contract solely between the Applicant and Companion Life.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Companion Life and that no person, entity or organization other than Companion Life shall be held accountable or liable to the Applicant for any of Companion Life's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Companion Life other than those obligations created under other provisions of this Contract.

Dated at (City) _____, [South Carolina], this _____, day of _____, _____

Name of Application (Company Name)

By: _____
(Authorized Signature)

(Signature of Agent/Broker)



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

READABILITY COMPLIANCE CERTIFICATION

TITLE OF FORMS: Group High Deductible Health Insurance Policy

Form Number : GHDHP 1010 (06/08)

I hereby certify that the above referenced forms produce a Flesch reading ease score as follows:

Flesch Index: 41.7

I further certify that to the best of my knowledge and belief these forms are in compliance with the NAIC Model Act regarding simplified and readable insurance policies.

A handwritten signature in black ink, appearing to read 'F. David Wythe', written over a horizontal line.

F. David Wythe, FLMI, HIA
Director, Compliance

Dated: August 19, 2008



COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

CONSUMER INFORMATION NOTICE

TO BE ATTACHED TO HOSPITAL/SURGICAL FORM GHDHP 1010 (08/08)

ISSUED IN THE STATE OF ARKANSAS

THE FOLLOWING NOTICE IS REQUIRED BY ACA 23-79-138:

Policyholder Service Office of Company:

Address:

Telephone Number:

[Name of Agent:

Address:

Telephone Number:]

If We at Companion Life Insurance Company fail to provide you with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201-1904
(800) 852-5494
(501) 371-2640



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, Columbia, South Carolina 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

After a review of Arkansas Bulletin 9-85, dated May 10, 1985 and Arkansas Bulletin 9-85A, dated July 18, 1985, Companion Life Insurance Company certifies that benefits payable under PPO and Non-PPO providers complies with the requirements specified in said bulletins.



Karl C. Kemmerlin .
Vice President & CFO

Dated: September 23, 2008



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
PO Box 100102, Columbia, SC 29202-3102
(803) 735-1251 (herein called "Companion Life")

hereby issues GROUP POLICY NUMBER: [xxxxxxx] (herein called "this Policy")
with POLICY EFFECTIVE DATE: [Month Day, Year]
to the POLICYHOLDER: [ABC Company]
(herein called "the Employer")
in STATE OF DELIVERY: [State]
on POLICY ISSUE DATE: [Month Day, Year];

and agrees to pay the benefits described in this Policy, subject to its terms and conditions, with respect to Insured Persons as defined herein.

This Policy is issued to the Employer named above in consideration of, and reliance upon, the statements made in the attached Application and timely premium payment as stated in this Policy.

The first premium is due and payable on or before the Policy Effective Date shown above. Subsequent premiums are due and payable as stated in the Premiums section of this Policy.

This Policy takes effect at 12:01 AM at the Employer's business address shown on the attached Application on the Policy Effective Date shown above. It continues in effect until the date it is canceled or terminated as provided in the Cancellation, Termination and Renewal section of this Policy, unless it is renewed (at the sole option of Companion Life) in accordance with the provisions of that section.

This Policy is governed by the laws of the State of Delivery shown above. If a policy conflicts with the state laws of Arkansas the provision will be administered according to the law.

Signed for Companion Life Insurance Company at Columbia, South Carolina on the Policy Issue Date shown above by:

A handwritten signature in black ink, appearing to read 'Trescott N. Hinton, Jr.'.

Trescott N. Hinton, Jr.
President

**GROUP HIGH DEDUCTIBLE
HEALTH INSURANCE POLICY**

INTRODUCTION

This policy is divided into two sections:

- the employer section
- the employee section

Both sections together form the policy and include all of the benefits available under a plan.

Premiums

A. Premium Payment

[Base] Premiums are due and payable on the [XXth] day of each month[, and Claims-Based Premiums are due on the date of written notice of such premiums by Companion Life to the Employer]. Payment of the appropriate premium constitutes an acceptance of the premium rate.

B. Determination of the Premium

The premium for this Policy will be determined on the basis of the rates indicated on the Schedule of Premium Rates section of this Policy, subject to the right of Companion Life to revise the rates on any of the following dates (after the first twelve (12) months this Policy is in effect):

1. any premium due date. Companion Life will notify the Employer at least forty-five (45) days in advance of the Effective Date of said revision;
2. on any Effective Date of a change in the terms of this Policy

If a revision is made to the rates for this Policy, the revised rates will be the basis for future premiums, until subsequently revised.

C. Change in Coverage

1. If coverage under this Policy is changed due to a change in the terms of the Policy, any premium charge or credit will be computed as of the Effective Date of the change.
2. The following provision is applicable if the increase, decrease, addition or termination, respectively, is not due to a change in the terms of the Policy.

If coverage is decreased or terminated after the first day of any billing month that this Policy remains in force, premiums relating to the decrease or termination will cease at the end of the billing month in which the decrease or termination is effective.

If coverage is increased or added after the first day of any billing month that this Policy remains in force, premiums relating to the increase or addition will begin on the first day of next billing month following the date the increase or addition is effective.

D. Clerical Error

If it is determined that premiums are due Companion Life, or that a premium refund is due as a result of a clerical error, all such premiums or refunds will be calculated at the appropriate premium for the period involved and will be limited to a maximum of twelve (12) months.

Premiums (Continued)

E. Grace Period

The Employer is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy continues in force, unless the Employer has given Companion Life written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The Employer shall continue to be liable to Companion Life for the payment of a pro ratio premium for the time the policy was in force during the grace period. If Companion Life agrees to continue this Policy beyond the end of the grace period, payment of any premium is payable to Companion Life for the time coverage under this Policy is continued in force.

General Provisions

1. Right to Amend

Companion Life may from time-to-time amend this Policy and the certificates issued hereunder. The change or amendments will not be effective until after thirty-one (31) days written notice to the Employer; however, increases in benefits provided or decreases in the premiums for this Policy may be made effective without notice. Notice of an amendment will be effective to the Employer or to an Employee when addressed to the Employer's office as shown in the Application to this Policy. Companion Life has no responsibility to provide individual notice to each Employee that an amendment to this Policy has been made.

2. Entire Contract

The entire contract is made up of: (a) the Policy; (b) the application for coverage under the Policy; and (c) any subsequent amendment, rider or endorsement to the Policy. A copy of the policyholder's application must be attached to the policy when issued. All statements made by the policyholder or by the persons insured are considered representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

No agent, except Our President, Vice President, Secretary or Assistant Secretary, can extend the time for payment of any premium. A change to the Policy which requires the Policyholder's consent will be valid only if signed by the Policyholder and Our President, Vice President, Secretary or Assistant Secretary. A change to a Policy which requires Your consent will be valid only if signed by You and Our President, Vice President, Secretary or Assistant Secretary.

Except as specifically provided herein, this Policy shall not make Companion Life liable or responsible for any duty or obligation which is imposed on the Employer by Federal or State law or regulations. To the extent that this Policy may be a welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Employer shall be the administrator of the welfare benefit plan and shall be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the welfare benefit plan, except those specifically undertaken by Companion Life herein.

General Provisions (Continued)

3. Time Limit on Certain Defenses

The validity of the policy may not be contested after it has been in force for two years from its date of issue. No statement, except fraudulent misstatements, made by any Insured Person covered under the policy relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the Insured Person's lifetime unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

4. Claim for Payment of Benefits

- a. An Insured Person must present an identification card when applying for Covered Expenses under this Policy.
- b. Written notice of care on which a Claim is based must be furnished to Companion Life, at its address shown on the face of the Policy, within twenty (20) days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, Companion Life will furnish or cause to be furnished to the Insured Person a Claim form. If the Claim form is not furnished within 15 days after the receipt of the notice by Companion Life, the Insured Person will be deemed to have complied with the requirements of this Policy as to proof of loss, if the Insured Person submits written proof covering the character and extent of the loss within the policy time fixed for filing proof of loss.
- c. An Insured Person must complete or cause to be completed a Claim, on forms prescribed by Companion Life, and will file it or cause it to be filed, along with all documentation required by Companion Life.
- d. The Claim must be received by Companion Life within ninety (90) days after the beginning of care; however, failure to file the Claim within the ninety (90) day period will not prevent payment of benefits if the Insured Person shows that it was not reasonably possible to timely file the Claim, provided the Claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, later than 12 months following the date proof of loss is otherwise required.
- e. The Claim will be deemed written proof of loss and written authorization from the Insured Person to Companion Life to obtain any medical or financial records and documents useful to Companion Life; however, Companion Life is not required to obtain any additional records or documents to support payment of a Claim and is responsible to pay Claims only on the basis of the information supplied to it at the time the Claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured Person's Claim will be deemed to be acting as the agent of the Insured Person.

General Provisions (Continued)

5. Payment of Claims

Companion Life will pay all benefits directly to the Employee upon receipt of due proof of loss. However, if an Insured Person provides Companion Life with a valid assignment form, Companion Life will pay all or any part of the benefits directly to the Provider. Any such payment made by Companion Life in good faith shall fully discharge the Company's liability to the extent of the payment. Companion Life will also pay benefits as described in Section IV of this Policy directly to a Provider if Companion Life has a written agreement with the Provider that provides for direct payment of benefits.

Benefits will be paid, with or without an assignment from an Insured Person, to public hospitals or clinics for services and supplies provided to the Insured Person if a proper claim is submitted by the public hospital or clinic. No benefits will be paid to the public hospital or clinic if such benefits have been paid to the Insured Person prior to receipt of the claim by Companion Life. Payment to the public hospital or clinic of benefits will discharge Companion Life from all liability to the Insured Person to the extent of the benefits so paid. Nothing in this section will be construed to require payment of benefits for the same services or supplies to both the Insured Person and the public hospital or clinic.

If this Policy is an integral part of an employee welfare benefit plan subject to the provision of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Companion Life is a claim fiduciary. As claim fiduciary, Companion Life shall have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by this Policy. Any judicial review of a decision of Companion Life shall be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

6. Time Payment of Claim

Payments for a covered claim will be paid within thirty (30) days after receipt of due written proof of loss; or the Participant, the Participant's assignee, health care professional, or health care facility will be notified that additional documentation is needed. All other benefits will be paid as soon as the required proof of loss is received.

7. Information and Records

Companion Life is entitled to obtain such authorization for medical and Hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification that the care and treatment received by the Insured Person was Medically Necessary, provided, however, that Companion Life will in every case hold such records as confidential except as authorized by an Insured Person.

General Provisions (Continued)

8. Review of Claims Denied In Whole or In Part

An Insured Person has sixty (60) days, from the date of receipt of notification of Companion Life's action on his or her Claim, to request a review of any benefits denied in whole or in part.

To request a review, the Insured Person must write to Companion Life stating the issue to be reviewed and attach to the request for review pertinent medical records or other information that the Insured Person offers in support of his or her Claim; the Insured Person may also request a description of any pertinent records that Companion Life relied on in making its original decision to deny the Claim in whole or in part.

A disposition of the Claim will not be deemed final until the time Companion Life renders its written decision. The written decision will be rendered within sixty (60) days after the request for review is received unless medical records are requested, in which case the decision will be rendered no later than one hundred twenty (120) days after the request for review is received. When a request for review is made later than sixty (60) days after notification of Companion Life's action, the foregoing time limitations shall not apply, but the review shall be made promptly while giving priority to requests made within sixty (60) days. Companion Life will send the Insured Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Policy provisions.

9. Legal Actions

No action at law or in equity will be brought to recover on this Policy until an Insured Person has exhausted the review procedure set forth in paragraph 6 above, nor will such action be brought after the expiration of five (5) years after the date written proof of loss is required to be furnished.

10. Identification Cards and Certificates

Companion Life will issue to the Employer for delivery to each Employee covered hereunder an identification card and an individual certificate summarizing the benefits to which the Employee is entitled. If any amendment to this Policy shall materially affect any benefits described in the certificate, new certificates or endorsements describing the changes will be issued.

11. Physical Examination

Companion Life at its own expense will have the right and opportunity to examine the Insured Person whose Injury or Illness is the basis of Claim, when and as often as it may reasonably require, during the pendency of a Claim or action hereunder.

12. Worker's Compensation

This Policy is not in lieu of and does not affect any requirements for coverage for Workers' Compensation Insurance.

General Provisions (Continued)

12. Conformity of State Statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is issued is amended to conform to the minimum requirements of such State.

13. Right of Reimbursement

If any payment under this Policy is made to or on behalf of a Covered Plan Participant on account of any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, the Employer and/or this Policy shall have a right to be reimbursed by the Covered Plan Participant (out of any settlement or judgments recovered which include payments for medical expenses) one dollar (\$1.00) for each dollar paid under the terms of this Group Health Plan Description without reduction for attorney's fees or costs incurred by the Covered Plan Participant in obtaining such settlements or judgments.

The Employer's and/or this Policy's right of reimbursement shall be in addition to any subrogation right or claim available to the Employer, and the Covered Plan Participant shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by Companion Life, on behalf of the Employer and/or this Policy, to exercise the Employer's and/or this Policy's right of reimbursement hereunder. No waiver, release of liability, or other documents executed by the Covered Plan Participant, without notice to and written consent of Companion Life, acting on behalf of the Employer, shall be binding upon the Employer.

14. Choice of Provider

You shall have the sole right to select Your own Physician and medical facilities. The Physician-patient relationship shall be maintained. However, Covered Charges and payment of benefits shall be as provided under the terms of the Policy.



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
PO Box 100102, Columbia, SC 29202-3102
(803) 735-1251 (herein called "Companion Life")

Companion Life Insurance Company, herein called the Company, hereby certifies that it has issued and delivered to the Policyholder a group health plan. The group Policy covers certain Covered Persons as described in the Policy.

This Certificate describes the benefits and provisions of the Policy. This Certificate becomes effective only if: (1) the Insured is eligible for insurance; (2) We have received the Insured's application/enrollment form; (3) the required premium has been paid; and (4) the Insured becomes insured in accordance with all of the provisions of the Policy.

No agent may change the Policy or waive its provisions.

This Certificate takes the place of any other certificate previously issued to the Insured under the Policy. It should be kept in a safe place.

Carefully read this Certificate including all provisions, benefits and limitations as soon as you receive it. It is important that you understand and are satisfied with the coverage provided under this Certificate.

IN WITNESS WHEREOF Companion Life Insurance Company caused this Certificate to be executed on the Date of Issue to take effect on the Certificate Effective Date.

For service or complaints about the policy, please address any inquiries to the address shown above or call [1-800-753-0404].

A handwritten signature in black ink, appearing to read 'Trescott N. Hinton, Jr.', written in a cursive style.

Trescott N. Hinton, Jr.
President

**GROUP HIGH DEDUCTIBLE HEALTH INSURANCE
CERTIFICATE OF COVERAGE**

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[SCHEDULE OF BENEFITS]

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-753-0404 to find out if your Provider is a Participating Provider.

General Provisions	
<p>When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Covered Persons subject to the terms of this Plan of Benefits. When a Benefit has a “Non-Covered” notation associated with it, the Benefit is not available to the Covered Person. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.</p>	
Probationary Period:	Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following [60] days of employment.
Minimum hours per week:	At least [30] hours per week.
Minimum weeks per year:	At least [48] weeks per year.
The column to the right identifies other group classifications, as defined by the Employer, that may participate in this Plan of Benefits:	<ul style="list-style-type: none"> •Contracted Workers •Appointed/Elected Officials •Board Members •Partners •Major Stockholders •Retirees
Benefit Year Deductible:	<p>[\$5,000] per Covered Person per Benefit Year, at a Participating Provider, limited to 3 per family.</p> <p>[\$7,500] per Covered Person per Benefit Year, at a Non-Participating Provider, limited to 3 per family.</p> <p>Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.</p>
Annual Out-of-Pocket Maximum:	<p>[\$5,000] per Covered Person, and [\$7,500] per family at a Participating Provider.</p> <p>[\$7,500] per Covered Person, and [\$10,000] per family at a Non-Participating Provider.</p> <p>Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.</p> <p>Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.</p> <p>The Coinsurance for Mental Health Services and Substance Abuse Services does not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits. If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will not accumulate toward the Out-of-Pocket Maximum.</p>

SCHEDULE OF BENEFITS

General Provisions (Continued)

Lifetime Maximum: \$2,000,000 per Covered Person.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is \$100 for a Participating Provider and \$200 for a Non-Participating Provider.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The initial Benefit Year is [01/1/08 through 12/31/08]. The Anniversary Date is [01/01].

Covered Expenses incurred during the last three (3) months of a Benefit Year, which are applied toward satisfying that year's Benefit Year Deductible will be carried over and applied toward satisfying the next year's Benefit Year Deductible.

Provided that there was no lapse in insurance coverage between the prior Plan and this Plan of Benefits, Covered Expenses incurred by a Covered Person during the last four (4) months of the Employer's previous Plan which were applied toward satisfying any deductible, Out-of-Pocket Maximum and Lifetime Maximum under that Plan, will be carried over and applied toward satisfying the initial Benefit Year Deductible, Out-of-Pocket Maximum or Lifetime Maximum.

In the event that two or more Covered Persons of one family incur charges for Covered Expenses as a result of injuries received in the same accident, only one Benefit Year Deductible will be applied to Covered Expenses that are incurred by all such Covered Persons as a result of injuries sustained in that same accident.

All Admissions require Pre-Certification. If Pre-Certification is not obtained, room and board charges will be denied. Other services may also require Pre-Certification. Please see the Schedule of Benefits and Plan of Benefits for more information.

Pre-Certification is required for the following outpatient Benefits:

MRI

MRA

CT Scans

PET Scans

Nuclear Cardiology Exam

Sclerotherapy

Septoplasty

Any surgical procedure that may be potentially cosmetic: i.e. blepharoplasty, reduction mammoplasty

Hysterectomy

Investigational procedures

Benefits for MRIs, MRAs, CT Scans, PET Scans and Nuclear Cardiology exams will be denied with Pre-Certification is not obtained or approved by the Companion Life. Benefits for any other outpatient services that require Pre-Certification will be reduced by 50% of the Allowable Charge when Pre-Certification is not obtained or approved by the Companion Life.

The coverage for Members may terminate on any given day during the term of this Plan of Benefits.

SCHEDULE OF BENEFITS

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital charges for room and board related to Admissions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient physical rehabilitation services (limited to a lifetime maximum payment of \$100,000) when Pre-Certified by the Companion Life and performed at a Provider designated by the Companion Life	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Skilled Nursing Facility Admissions (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Long Term Acute Care Hospital (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Lab, x-ray and other diagnostic services performed at an independent laboratory facility	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
True Emergency Room Visits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Non-true Emergency Room Visits (Copayment waived if admitted)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$50 Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and after the Covered Person pays a \$100 Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other covered outpatient Benefits	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES		
	Participating Provider	Non-Participating Provider
Physician Services in a Hospital	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Physician services for lab, x-ray and other diagnostic services	<p>The Company pays 100% of the Allowable Charge after the Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Services in the Physician's office (other than Mental Health Services, Mental Health Conditions, Maternity Care, Substance Abuse Services, physical therapy, dialysis treatment and second surgical opinion)	<p>The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Physician Services in the Covered Person's home	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

PHYSICIAN SERVICES OTHER THAN MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Second surgical opinion	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
All other Physician Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES

Mental Health and Substance Abuse Services are limited to a combined total of thirty (30) days of inpatient care (Admission) or twenty (20) outpatient appointments per Covered Person per Benefit Year. This combined total does not apply to Mental Health Conditions. As with all other Benefits, Covered Expenses included in this section apply to the Lifetime Maximum. Additionally, there is a \$10,000 lifetime maximum payment for Substance Abuse Services for each Covered Person. Pre-Certification is required for Mental Health Services, Mental Health Conditions and Substance Abuse Services. If Pre-Certification is not obtained or approved by the Companion Life, the following penalties will apply.

**Inpatient: Denial of room and board
Outpatient: 50% of the Allowable Charge
Office: 50% of the Allowable Charge**

	Participating Provider	Non-Participating Provider
Inpatient Hospital charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Hospital charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Hospital charges for Substance Abuse Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient Hospital or clinic charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Outpatient Hospital or clinic charges for Substance Abuse Services and for the treatment of Alcohol Abuse	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Inpatient Physician charges for Mental Health Conditions	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Medically necessary services for the treatment of autism spectrum disorders (ASD) when the criteria of the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR) are met	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Inpatient Physician charges for Substance Abuse Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient or Office Physician charges for Mental Health Services	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Outpatient Physician charges for Mental Health Conditions	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Office Physician charges for Mental Health Conditions	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge

SCHEDULE OF BENEFITS

MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Outpatient or Office Physician charges for Substance Abuse Services	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES		
	Participating Provider	Non-Participating Provider
Ambulance service: Ground transport to and from a Hospital in an ambulance (benefit includes air ambulance)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Durable Medical Equipment, Prosthetics and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is \$500 or more, Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services.	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Medical Supplies	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Member must pay the balance of the Provider's charge</p>
Home Health Care, including private duty nursing services (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Maternity	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Hospice Care (Pre-Certification is required)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Provider Charges for physical therapy and occupational therapy (Limited to a \$1,000 combined maximum Benefit per Covered Person per Benefit Year. Please see the "Outpatient Rehabilitation" section in Section IV for further limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Speech therapy (Please "Outpatient Rehabilitation" in Section IV for limitations)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
<p>Radiation therapy</p> <p>Cancer chemotherapy</p> <p>Respiratory therapy</p> <p>Pre-certification is required</p>	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy.	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider’s charge</p>
In Vitro Fertilization	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider’s charge</p>
<p>Human organ and tissue transplant services (excluding drugs), limited to a \$250,000 maximum payment per Covered Person per lifetime and with the following individual organ transplant limits:</p> <p>Bone Marrow/Stem Cell \$250,000</p> <p>Cornea \$ 25,000</p> <p>Heart \$120,000</p> <p>Heart/Lung \$130,000</p> <p>Heart/Lung (double) \$250,000</p> <p>Kidney \$ 60,000</p> <p>Kidney (double) \$120,000</p> <p>Lung (double) \$250,000</p> <p>Lung/Segmental Lung \$130,000</p> <p>Liver/Segmental Liver \$225,000</p> <p>Pancreas \$ 80,000</p> <p>Pancreas and Kidney \$ 80,000</p> <p>Human organ and tissue transplant services are only covered if provided at a transplant center approved by the Company in writing</p> <p>Physician Charges are subject to the Benefit Year Deductible.</p>	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person’s Benefit Year Deductible and Copayment</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible and Copayment</p> <p>The Covered Person must pay the balance of the Provider’s charge</p>

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Allergy Injections	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment. Office services by a Specialist will be paid at 100% of the Allowable Charge after a \$30 Copayment.	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Acupuncture	Non-Covered	Non-Covered
Chiropractic Services, including related x-rays, modalities and office visits, limited to a \$500 maximum payment and 20 visits per Covered Person per Benefit Year	The Company pays 100% of the Allowable Charge after the Covered Person pays a \$20 Copayment	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Cosmetic Services	Non-Covered	Non-Covered
Disease Management Program	Covered	Non-Covered
Health Questions Hotline	Covered	Non-Covered
Hearing Aids	Non-Covered	Non-Covered
Oxygen (Pre-Certification is required)	Covered	Covered
Impacted tooth removal	The Company pays 90% of the Allowable Charge after the Benefit Year Deductible The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible	The Company pays 65% of the Allowable Charge after the Benefit Year Deductible The Covered Person must pay the balance of the Provider's charge
Impotence treatment	Non-Covered	Non-Covered
Online Health Assessment Program	Covered	Non-Covered
Massage Therapy	Non-Covered	Non-Covered
Maternity Management Program	Covered	Non-Covered
Tobacco Cessation Program	Covered	Non-Covered

SCHEDULE OF BENEFITS

OTHER SERVICES (CONTINUED)		
	Participating Provider	Non-Participating Provider
Speech or Hearing Impairment	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Temporomandibular Joint Disorder (TMJ) including treatment, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Orthognathic surgery, limited to \$500 per Covered Person per Lifetime	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>
Phenylketonuria (PKU) Formula	Covered	Covered
Weight Control Program	Covered	Non-Covered
Supplemental Accident benefits (the first \$300 incurred per Benefit Year is payable at 100% and is not subject to the Benefit Year Deductible)	<p>The Company pays 90% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person pays the remaining 10% of the Allowable Charge after meeting the Covered Person's Benefit Year Deductible</p>	<p>The Company pays 65% of the Allowable Charge after the Benefit Year Deductible</p> <p>The Covered Person must pay the balance of the Provider's charge</p>

SCHEDULE OF BENEFITS

ANNUAL BENEFITS		
The Benefit Year Deductible does not apply to these Benefits.		
	Participating Provider	Non-Participating Provider
Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	Non-Covered
Physical exam (limited to \$250 per Covered Person per Benefit Year for Covered Persons 40 or older)	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Prostate examination, screenings, and laboratory work (limited to one (1) per Benefit Year)	The Company pays 100% of Allowable Charge	Non-Covered
Colorectal Cancer Screenings (limited to: <ul style="list-style-type: none"> • One (1) fecal occult blood testing of three consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy once every five years • One (1) double contract barium enema every five years • One (1) colonoscopy every ten years) 	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Well child care performed in the Physician's office and immunizations for Dependents up to age 6	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$60 Copayment
Gynecological exam (limited to two (2) per Benefit Year) The \$250 per Covered Person per Benefit Year physical exam maximum will apply. Once this maximum is met the contract Benefit Year Deductible and Coinsurance will apply.	The Company pays 100% of the Allowable Charge after the Covered Person pays the \$20 Copayment	Non-Covered
Mammography screenings: <ul style="list-style-type: none"> • One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. • A mammogram once every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician. • A mammogram every year for any woman who is fifty (50) years of age or older. <p>Such coverage shall not exceed the cost of the examination.</p>	The Company pays 100% of Allowable Charge	Non-Covered

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Generic Drugs	The Covered Person pays a \$20 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$10 Copayment after meeting the Covered Member's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$10 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Preferred Brand Drug	The Covered Person pays a \$55 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$25 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$25 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Non-Preferred Brand Drug	The Covered Person pays a \$95 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Covered Person pays a \$40 Copayment after meeting the Covered Person's Benefit Year Deductible, up to a 60-day supply	The Company pays 100% of the Allowable Charge after a \$40 Copayment per Covered Person and after the Benefit Year Deductible, up to a 60-day supply The Covered Person must pay the remaining balance of the Provider's Charge
Contraceptives (Prescription Drugs)	Covered	Covered	Covered
Prescription Drugs used for smoking cessation	Covered	Covered	Covered
Prescription Drug Deductible*	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year	\$100 per Covered Person per Benefit Year

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG BENEFIT (CONTINUED)			
Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Maximum Prescription Drug Benefit	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)	\$0 (No Maximum Prescription Drug Benefit)
Prescription Drugs used for obesity/weight control	Non-Covered	Non-Covered	Non-Covered
Diabetic syringes and supplies	Covered	Covered	Covered

*The Prescription Drug deductible is integrated in the Benefit Year Deductible. Once the Benefit Year Deductible is satisfied the Prescription Drug deductible is satisfied, and the Covered Person is only responsible for remaining Copayment.]

[About Health Savings Accounts

This high deductible policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This contract may qualify you to make a pre-tax annual contribution to a Health Saving Account (HSA).

The high Deductible Plan is not a “health savings account” or an “HSA,” but is designed as an HSA compatible high deductible health plan that may allow you, if you are an eligible individual, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the Deductible under this Contract.

NOTICE: The Company does NOT provide tax advise. If you intent to purchase this Contract to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

This Contract is designed to meet government requirements for an HSA compatible high Deductible health Contract to be used in conjunction with establishing eligibility for HSA tax benefits. Although the Company believes that the Contract meets these requirements, the Internal Revenue Service has not ruled on whether the Contract is qualified as an HSA compatible high Deductible health Contract.

Should you purchase this Contract in order to obtain income tax benefits associated with an HSA, and the Internal Revenue Service were to rule this Contract does not qualify as a high Deductible health Contract, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.]

Section I - Definitions

1. “Accident” means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.
2. “Accidental Dental Injury” means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for disease or illness.
3. “Actively-At-Work” means You will be considered to be actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the Usual way, all of the regular duties of Your job on a full time basis on that day. You will be deemed to be actively at work on a day which is not one of Your Employer's scheduled work days only if You Were actively at work on the preceding scheduled work day.
4. “Admission” means the period of time between an Insured Person’s entry as an Inpatient into a Hospital or Skilled Nursing Facility and the time the Insured Person leaves or is discharged from the Hospital or Skilled Nursing Facility.
5. “Adoption or Adopt(ed)” means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents.
6. “Adverse Benefit Determination” means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Evidence of Coverage with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.
7. “Allowance” means the maximum amount upon which payment will be based for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered was not a PPO provider. This Allowance is determined and established solely by Companion Life and is based upon many factors. Such factors may (but not necessarily will) include: pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area established by Companion Life; and/or the cost of providing the Covered Service. The Allowance may be modified by Companion Life at any time without the consent or notice to the Employer or any Covered Plan Participant.
8. “Allowed Amount” means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount is the PPO Schedule Amount when the Provider who rendered the Covered Service(s) was a Preferred PPO Provider, and the Allowance when the Provider who rendered the Covered Service(s) was not a Preferred PPO Provider. Further, under the Group Health Plan Program, the allowed Amount means the maximum amount upon which Companion will base payment to the applicable Host Plan for Covered Services provided in the applicable Host Plan’s geographic area. Each Allowed Amount is determined and established by Companion Life and is subject to change at any time without notice to or consent of the Employer or any Covered Plan Participant.

Section I – Definitions (Continued)

9. “Ambulance” means a ground or water vehicle, airplane or helicopter properly licensed pursuant to applicable law in the state of issue.
10. “Ambulatory Surgical Center” means a facility properly licensed, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.
11. “Anniversary Date” means the date, one year after the Effective date and subsequent annual anniversaries of that date.
12. “Application For Group Insurance/Membership” means the Companion Life form that individual(s) must submit to the Employer when applying for coverage during the 30-day period immediately following the date that individual(s) first became eligible for coverage under the Policy, or as part of the Employer’s initial enrollment.
13. “Artificial Insemination (AI)” means a medical procedure in which sperm is placed into the female productive tract by a qualified health care provider for the purpose of producing a pregnancy.
14. “Birth Center” means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.
15. “Bone Marrow Transplant” means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “Bone Marrow Transplant” includes the transplantation as well the administration of chemotherapy and the chemotherapy drugs. The term “Bone Marrow Transplant” also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).
16. “Breast Reconstruction Surgery” means surgery to reestablish symmetry between the two breasts.
17. “Calendar Year” begins January 1st and ends December 31st in any given Calendar Year.
18. “Cardiac Therapy” means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.
19. “Certified Nurse Midwife” means a person who is licensed as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Section I – Definitions (Continued)

20. “Certified Registered Nurse Anesthetist” means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category.
21. “Claim Involving Urgent Care” means any request or application for coverage or benefits for medical care or treatment that has not yet been approved to the Covered Plan Participant with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize the Covered Plan Participant’s life or health or the Covered Plan Participant’s ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Covered Plan Participant’s Condition, would subject the Covered Plan Participant to severe pain that cannot be adequately managed without the proposed services being rendered.
22. “Coinsurance” means the sharing of health expenses for Covered Services between the Policy and the Covered Plan Participant. After the Covered Plan Participant’s Deductible requirement is met, the Policy will pay a percentage of the Allowed Amount for Covered Services, as set forth in the Schedule of Benefits.
23. “Concurrent Care Decision” means a decision by Companion Life and/or the Employer to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if Companion Life and/or the Employer had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.
24. “Condition” means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Covered Plan Participant.
25. “Copayment (if applicable)” means the dollar amount established which is required to be paid to a health care Provider by a Covered Plan Participant at the time certain Covered Services are rendered by that Provider. While this amount may vary depending on, among other things, the contracting status of the health care Provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Benefits for the service. Except as otherwise established, if more than one Covered Service is rendered by a health care Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.
26. “Covered Dependent” means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Policy other than as a Covered Employee.
27. “Covered Employee” means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Policy other than as a Covered Dependent.

Section I – Definitions (Continued)

28. “Covered Plan Participant” means the Covered Employee or Covered Dependent who meets and continues to meet the applicable eligibility requirements of the Employer and is actually covered under the Policy.
29. “Covered Services” means those Medically Necessary Health Care Services described in the Covered Expenses Section. The term Health Care Services includes, as applicable, any treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.
30. “Creditable Coverage” means health care coverage which is continuous to a date within 63 days of the Covered Plan Participant’s Enrollment Date. Such health care coverage may include the following:
1. a group health plan;
 2. individual health insurance
 3. Medicare Part A and Part B;
 4. Medicaid;
 5. benefits to members and certain former members of the uniformed services and their dependents;
 6. a medical care program of the Indian Health Service or a tribal organization;
 7. a State health benefits risk pool;
 8. a health plan offered under chapter 89 of Title 5, United States Code;
 9. a public health plan; or
 10. a health benefit plan of the Peace Corps.
31. “Custodial or Custodial Care” means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient’s diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.
32. “Deductible” means the amount of charges, up to the Allowed Amount, for Covered Services which a Covered Plan Participant must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Policy, before payment for Covered Services begins.
33. “Dependent” means:
- a. an Insured's spouse.
 - b. each unmarried child up to [19]years of age for whom the Insured is legally responsible.
 - c. each unmarried child from age [19 up to age 24] who is:
 - i. a full-time student at an accredited school or college; and
 - ii. primarily dependent on the Insured for support and maintenance.
 - d. each unmarried child age [19] who:
 - i. becomes Totally Disabled while insured under b. or c. above;
 - ii. is incapable of self-sustaining employment because of mental retardation or physical handicap; and

Section I – Definitions (Continued)

- iii. is primarily dependent on the Insured for support and maintenance.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days after the Company asks for it.

- 34. “Detoxification” means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, Covered Plan Participant is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk of the Covered Plan Participant at a minimum.
- 35. “Diabetes Educator” means a person who is properly certified to supervise diabetes outpatient self-management training and educational services.
- 36. “Dialysis Center” means an outpatient facility certified by the Health Care Financing Administration (or a similar regulatory agency in the state of issue) to provide hemodialysis and peritoneal dialysis services and support.
- 37. “Dietitian” means a person who is properly licensed to provide nutrition counseling for diabetes outpatient self-management services.
- 38. “Durable Medical Equipment” means equipment furnished by a supplier or a Home Health Agency that 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.
- 39. “Durable Medical Equipment Provider” means a person or entity that is properly licensed to provide home medical equipment, oxygen therapy services, or dialysis supplies in the patient’s home under a Physician’s prescription.
- 40. “Effective Date” with respect to the Employer and to Covered Plan Participants properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the cover of this Group Health Plan Description; and with respect to Covered Plan Participants who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section of this Evidence of Coverage.
- 41. “Eligible Dependent” means a Covered Employee’s 1) legal spouse and/or 2) natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Covered Employee or the Covered Employee’s legal spouse has been court-appointed as legal guardian or legal custodian) who is :
 - 1. dependent upon the Covered Employee for financial support;
 - 2. under the limiting age set forth in the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage Section; and
 - 3. living in the household of the Covered Employee or a full-time or part-time student.

A newborn child of a Covered Plan Participant other than the Covered Employee or the newborn child of a Covered Plan Participant other than the Covered Employee’s spouse is an Eligible Dependent hereunder. Coverage for such child will automatically terminate 18 months after the birth of the newborn child.

Section I – Definitions (Continued)

42. “Eligible Employee” means an employee who meets all of the eligibility requirements set forth in the Eligibility Requirement for Covered Employees subsection of the Eligibility for Coverage Section, and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee.
43. “Employer” means an entity which has established this plan for the purpose of providing coverage and/or benefits to Coverage Plan Participants.
44. “Endorsement” means any amendment to the Policy or the Certificate of Coverage.
45. “Enrollment Date” means the date of enrollment of the individual under the Policy or, if earlier, the first day of the Waiting Period of such enrollment.
46. “Enrollment Forms” means those forms, which are used to maintain accurate enrollment files under the Policy. Such forms include: the Application for Group Insurance/Membership form and the Member status Change Request form.
47. “Experimental or Investigational” means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined either by the Employer or Companion Life:
1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Plan Participant;
 2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
 3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institution review board or other entity as required and defined by federal regulations;
 4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
 5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
 6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

Section I – Definitions (Continued)

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

“Reliable evidence” shall mean (as determined by the Employer or Companion Life):

1. records maintained by Physicians or Hospitals rendering care or treatment to the Covered Plan Participant or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;
5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by the Employer or Companion Life to be Experimental or Investigational are excluded (see the Covered Services Section). In determining whether a Health Care Service is Experimental or Investigational, Companion Life or the Employer may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

48. “Foster Child” means a person under the age of 18 who is placed in the Covered Employee’s residence and care by a regulatory agency in compliance with applicable laws.
49. “Gamete Intrafallopian Transfer (GIFT)” means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.
50. “Group Health Plan Description” means the written document (Policy) whereby coverage and/or benefits will be provided to Covered Plan Participants. The Group Health Plan Description includes the Certificate of Coverage, the Application for Group Insurance/Membership, the Member Status Change Request form, and any Endorsements to the Group Health Plan Description or the Certificate of Coverage.

Section I – Definitions (Continued)

51. “Health Care Services” includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.
52. “Home Health Care or Home Health Care Service” means Physician-directed professional, technical and related medical and personal care services provided on a visiting or part-time basis directly by (or indirectly through) a Home Health Agency in the Covered Plan Participant’s home or residence.
53. “Hospice” means a public agency or private organization which is duly licensed to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.
54. “Hospital” means a facility properly licensed that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial Care, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

55. “Identification Card” means the card(s) issued by Companion Life to the Covered Employees. The card is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the Policy.
56. “Independent Clinical Laboratory” means a laboratory properly licensed where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.
57. “Independent Diagnostic Testing Facility” means a facility, independent of a hospital or physician’s office, which is a fixed location, a mobile entity, or an individual non-physician practitioner where diagnostic tests are performed by a licensed physician or by a licensed, certified non-physician personnel under appropriate physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable laws of the State in which it operates. Further, such an entity must meet Companion Life’s criteria for eligibility as an Independent Diagnostic Testing Facility.

Section I – Definitions (Continued)

58. “In Vitro Fertilization (IVF)” means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the women’s uterus.
59. “Licensed Practical Nurse” means a person properly licensed to practice practical nursing pursuant to applicable state law(s).
60. “Massage or Massage Therapy” means the manipulation of superficial tissues of the human body by using the hand, foot, arm, or elbow.
61. “Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.
62. “Medically Necessary or Medical Necessity” means, for coverage and payment purposes only, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of the Employer or Companion Life:
1. consistent with the symptom, diagnosis, and treatment of the Covered Plan Participant’s Condition;
 2. widely accepted by the practitioners’ peer group as efficacious and reasonably safe based upon scientific evidence;
 3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
 4. not Experimental or Investigational;
 5. not for cosmetic purposes;
 6. not primarily for the convenience of the Covered Plan Participant, the Covered Plan Participant’s family, the Physician or other provider; and
 7. the most appropriate level of service, care or supply which can safely be provided to the Covered Plan Participant. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Covered Plan Participant in an alternative setting.
63. “Medicare” means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.
64. “Member Status Change Request” form means the form(s) provided by or acceptable to Companion Life, which a Covered Employee must complete and submit through the Employer and received by Companion Life, when adding or deleting a Covered Dependent.
65. “Mental Health Professional” means a person properly licensed to treat Mental and Nervous pursuant to applicable laws of the state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling services.
66. “Mental and Nervous Disorders” means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Section I – Definitions (Continued)

67. “Midwife” means a person properly licensed by midwifery pursuant to applicable state law(s).
68. “Morbid Obesity is a Condition” where a Covered Plan Participant is 100 pounds over their ideal body weight and/or Body Mass Index (BMI) of equal to or greater than 40.
69. “Occupational Therapy” means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.
70. “Orthotic Device” means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.
71. “Outpatient Rehabilitation Facility” means an entity which renders, through providers properly licensed pursuant to law(s) of the state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet Companion’s criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit or a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III “specialty rehabilitation hospital” described in applicable state law(s).
72. “Partial Hospitalization” means treatment in which the patient receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a “home” for purposes of this definition.
73. “Physical Therapist” means a person properly licensed to practice Physical Therapy pursuant to applicable state law.
74. “Physical Therapy” means the treatment of disease or injury by physical or mechanical means as defined in applicable state law(s). Such therapy may include traction, active or passive exercises, or heat therapy.
75. “Physician” means any individual who is properly licensed by applicable state law as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).
76. “Physician Assistant” means a person licensed pursuant to applicable state law(s).
77. “Placed, Placement, or To Place” means to the process of a person giving a child up for Adoption and the prospective parent receiving and Adopting the child, or the process where a Foster Child will reside with and be cared for by the Covered Plan Participant and includes all actions by any person or agency participating in the process, or as otherwise defined by applicable State Statutes.

Section I – Definitions (Continued)

78. “Post-Service Claim” means any paper or electronic request or application for coverage, benefits, or payment for a service actually provided to the Covered Plan Participant (not just proposed or recommended) that is received by Companion Life on a properly completed claim form or electronic format acceptable to Companion Life in accordance with the provisions of this section.
79. “PPO” means, or refers to, the network of PPO Providers available to Covered Plan Participants under this Evidence of Coverage.
80. “PPO Provider” means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to a Covered Plan Participant, was under contract with Companion Life to participate in Companion Life’s network of preferred Providers.
81. “PPO Schedule Amount” means the amount on which payment will be based for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was a Preferred PPO Provider. This amount is determined and established by Companion Life and is a pre-established maximum schedule amount which may vary by geographical area.

The amount of charges credited to the Deductible requirement will not exceed the Allowed Amount.

82. “Pre-Existing Condition” means medical advice, diagnosis, care, or treatment within the 6 month period ending on the enrollment date, and which extends for not more than 12 months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or 18 months after the enrollment date in the case of a late enrollee.

The Pre-existing Condition exclusionary period does not apply to:

1. pregnancy;
 2. a newborn child or an adopted newborn child;
 3. an adopted child who is covered under Creditable Coverage;
 4. Genetic Information in the absence of a diagnosis of the Condition;
 5. routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or
 6. Conditions arising from domestic violence.
83. “Pregnancy” means a Covered Person’s normal Pregnancy and the resulting normal childbirth, elective cesarean section or elective abortion.
84. “Pre-Service Claim” means any request or application for coverage or benefits for a service that has not yet been provided to the Covered Plan Participant and with respect to which the terms of the Policy condition payment for the service (in whole or in part) on approval by Companion Life and/or the Employer of coverage or benefits for the service before the Covered Plan Participant receives it. A Pre-Service Claim may be a Claim involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by Companion Life and/or the Employer regarding coverage, benefits, or payment for a service that has not actually been rendered to the Covered Plan Participant if the terms of the Policy do not require (or condition payment upon) approval by Companion Life and/or the Employer of coverage or benefits for the service before it is received.

Section I – Definitions (Continued)

85. “Prosthetist/Othotist” means a person or entity that is properly licensed to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs under a Physician’s prescription.
86. “Prosthetic Device” means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.
87. “Provider” means any facility, person or entity recognized for payment by Companion Life and defined in the Policy.
88. “Psychiatric Facility” means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Policy, a Psychiatric Facility is not a Hospital, as defined herein.
89. “Psychologist” means a person properly licensed to practice psychology pursuant to applicable state law(s).
90. “Registered Nurse” means a person properly licensed to practice professional nursing pursuant to applicable state law(s).
91. ”Registered Nurse First Assistant (RNFA)” means a person properly licensed to perform surgical first assisting services pursuant to applicable state law(s).
92. “Rehabilitative Therapies” means therapies the primary purpose of which is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but is not limited to, Physical Therapy, Speech Therapy, pain management, pulmonary therapy or Cardiac Therapy.
93. “Skilled Nursing Facility” means an institution or part thereof which meets Companion Life’s criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the State or similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by Companion Life.
94. “Speech Therapist” means a person properly licensed to practice Speech Therapy pursuant to applicable law.
95. “Speech Therapy” means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy services.
96. “Standard Reference Compendium” means: 1) The United States Pharmacopoeia Drug Information; 2) The American Medical Association Drug Evaluation; or 3) The American Hospital Formulary Service Hospital Drug Information.

Section I – Definitions (Continued)

97. “Substance Abuse Facility” means a facility properly licensed under applicable law to provide necessary care and treatment for Substance Dependency Care. For purposes of this Policy, a Substance Abuse Facility is not a Hospital.
98. “Substance Dependency” means a Condition where a person’s alcohol or drug use injures his or her social or economic functioning; or causes the individual to lose self-control.
99. “Traditional Insurance Providers” are those health care Providers who are not PPO Providers, but who or which have entered into a contract then in effect to participate in Companion Life’s traditional provider programs when such programs exist.
100. “Waiting Period” means the period of time specified if any, which must follow the date an individual is initially employed by the Employer before such individual may become a Covered Plan Participant.
101. “Zygote Intrafallopian Transfer (ZIFT)” means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

Section II – Eligibility and Enrollment

Eligibility

A. Eligible Class(es)

[All Full-Time Employees of the Employer]

B. Eligibility Date - Employee Insurance

1. Each Employee in an eligible class on the Policy Effective Date is eligible to be insured under this Policy on [that date.][the later of the Policy Effective Date or the day after he or she completes the Waiting Period selected by the Employer.]
2. An Employee who enters an eligible class after the Policy Effective Date is eligible to be insured under this Policy on [the day he or she enters an eligible class.][the day after he or she completes the Waiting Period selected by the Employer.]
3. An Employee who is insured, or eligible to be insured, under this Policy and then is laid off or put on a leave of absence and is then rehired by the Employer is considered a newly hired Employee. The provisions of this Policy which are applicable to newly hired Employees and their Eligible Dependents are applicable to rehired Employees and their Eligible Dependents.

C. The following individuals who meet the eligibility criteria specified below as an Eligible Dependent is eligible to apply for coverage under this Policy:

1. the Covered Employee's present spouse;
2. the Covered Employee's natural, newborn, adopted, foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year, in which the child reaches age 25, and who is:
 - a. dependent upon the Covered Employee for financial support; and
 - b. living in the household of the Covered Employee or a full-time or part-time student.
3. the newborn child of a Covered Plan Participant other than the Covered Employee or the newborn child of a Covered Plan Participant other than the Covered Employee's spouse. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.
4. Handicapped children – A handicapped dependent child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if such child is otherwise eligible for coverage under this Policy, incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of such child's handicap existed prior to such child's 25th birthday. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

Note: It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section II – Eligibility and Enrollment (Continued)

D. Eligibility Date - Dependent Insurance

Each Employee in a class eligible for Dependent insurance is eligible to have his or her Dependents insured under this Policy on the later of:

1. the date the Employee becomes eligible for Employee insurance under this Policy; or
2. the date the Employee first acquires a Dependent.

No person may be insured simultaneously as an Employee and as a Dependent under this Policy. No person may be insured simultaneously as a Dependent of more than one Employee under this Policy.

E. The following individuals may be added upon becoming an eligible Dependent of a Covered Employee:

1. **Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit a Member status Change Request form through the Employer to Companion Life prior to or during the 90-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

Companion Life must be notified, in writing, within 30 days after the birth. In the event the Employer is not notified before or within 90 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period.

Note: Coverage for a newborn child of a Covered Plan Participant other than the Covered Employee or the Covered Employee's spouse will automatically terminate 18 months after the birth of the newborn child.

2. **Adopted Newborn Child** – To enroll an Adopted child, the Covered Employee must submit a Member Status Change Request form through the Employer to Companion Life prior to or during the 60-day period immediately following the filing of the petition for adoption.

Effective Date of coverage for an Adopted newborn child, eligible for coverage, shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. Any Pre-existing Condition exclusionary period will not apply. The Employer may require the Covered Employee to provide any information and/or documents which Companion Life deems necessary in order to administer this provision.

In the event the Employer is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Employee provides notice to the Employer, and Companion Life receives the Member Status Change Request form within 60 days of the birth. In the event Companion Life is not notified before or within 60 days of the date of birth, the Covered Employee must make application during an Annual Open Enrollment Period.

If the Adopted newborn child is not ultimately Placed in the residence of the Covered Employee, there shall be no coverage for the Adopted newborn child. It is the responsibility of the Covered Employee to notify the Employer within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

Section II – Eligibility and Enrollment (Continued)

3. **Adopted/Foster Child** – To enroll an Adopted or Foster Child, the Covered Employee must submit a Member Status Change Request form through the Employer to Companion Life prior to or during the 30-day period immediately following the date of Placement. The Effective Date for an Adopted or Foster child (other than an Adopted newborn child) shall be the date such Adopted or Foster child is Placed in the residence of the Covered Plan Participant in compliance with applicable law. Any Pre-existing Condition exclusionary period will not apply to an Adopted child but will apply to a Foster child. The Employer may require the Covered Employee to provide any information and/or documents which Companion Life deems necessary in order to administer this provision.

In the event the Employer is not notified within 30 days of the date of Placement, the child will be added as of the date of Placement so long as the Covered Employee provides notice to the Employer, and Companion Life receives the Member Status Change Request form within 60 days of the Placement. In the event Companion Life is not notified before or within 60 days of the date of Placement, the Covered Employee must make application during an Annual Open Enrollment Period.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted Child. Proof of final Adoption must be submitted to Companion Life. It is the responsibility of the Covered Employee to notify the Employer if the Adoption does not take place. Upon receipt of this notification, Companion Life will terminate the coverage of the child on the first billing date following receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Covered Employee to notify Companion Life that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, Companion Life will terminate the coverage of the child on the first billing date following receipt of the written notice.

4. **Marital Status** – A Covered Employee may apply for coverage of an Eligible Dependent(s) due to marriage. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through the Employer to Companion Life. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent(s) who is enrolled as a result of marriage is the date of the marriage.
5. **Court Order** – A Covered Employee may apply for coverage of an Eligible Dependent outside of the initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee's plan. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through the Employer to Companion Life. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Section II – Eligibility and Enrollment (Continued)

F. Dependents Not Eligible for Benefits

The following Dependents are not eligible for benefits under this Policy in any case:

1. an Employee's former spouse who is legally divorced from the Employee, unless a court order decree directs otherwise, and then only until either the Employee or ex-spouse remarries;
2. an eligible Employee's Child nineteen (19) or more years of age, with the exception of:
 - a. an unmarried Child, nineteen (19) or more years of age who is unable to earn his or her own living due to physical or mental Illness or handicap; and
 - b. an unmarried Full-Time Student.

G. Continuation of Eligibility due to Mental or Physical Handicap

If an unmarried Child, who is insured under this Policy or was insured under a similar contract held by the Employer that this Policy replaces, is unable to earn his or her own living due to physical or mental Illness or handicap and he or she is at or reaches a terminating age under the terms of this Policy, he or she will be eligible under this Policy if Companion Life receives proof, satisfactory to Companion Life, that the Child is unable to earn his or her own living due to physical or mental Illness or handicap.

Companion Life reserves the right to require subsequent proof of incapability during the time the Dependent remains insured under this Policy. Proof will not be required more than once per year after the first year the Dependent remains insured under this provision.

Enrollment

To apply for coverage, the Eligible Employee must:

1. complete and submit, through the Employer, the Application for coverage under this Policy.
2. provide any additional information needed to determine eligibility, if requested by Companion Life.
3. complete and submit, through the Employer, a Member Status Change Request form to add Eligible Dependents or delete Covered Dependents.

Section II – Eligibility and Enrollment (Continued)

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Employer's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.
2. Employee/Spouse Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's present lawful spouse only.
3. Employee/Child(ren) Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's child(ren) only.
4. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

A. Enrollment Periods – The enrollment periods for applying for coverage are as follows:

1. Initial Enrollment Period is the period of the time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.
2. Annual Open Enrollment Period is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives, included in the Employer's health benefit program.
3. Special Enrollment Period is the 30-day period of time immediately following a special circumstances during which an Eligible Employee or Eligible Dependent may apply for coverage.

B. Employee Enrollment

1. An individual who is an Eligible Employee on the Employer's Effective Date must Enroll during the Initial Enrollment Period. The Eligible Employee shall become a Covered Employee as of the Effective Date of the Employer. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Covered Employee's Effective Date.
2. An individual who becomes an Eligible Employee after the Employer's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will be on the date specified on the Group Application.

Section II – Eligibility and Enrollment (Continued)

C. Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Application for Group Insurance/Membership form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period. Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

D. Special Enrollment Period

An Eligible Employee who declined coverage in writing at the time of his/her Initial Enrollment Period may apply for coverage due to loss of eligibility for coverage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the applicable Enrollment Form and forward it to his/her Employer. The Eligible Employee must make application for enrollment within 30 days of the special circumstance.

Loss of Eligibility of Coverage – An Eligible Employee and/or Eligible Dependent(s) may request enrollment outside the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

1. was covered under another group health benefit plan as an employee or dependent, or was covered under other health insurance coverage or, was covered under COBRA continuation of coverage at the time he or she was initially eligible to enroll for coverage under the Group Health Plan Description;
2. when offered coverage at the time of initial eligibility, stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment;
3. demonstrates that he or she has lost coverage under a group health benefit plan or health insurance coverage within the past 30 days as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage; and
4. requests enrollment within 30 days after the termination of coverage under another employer health benefit plan.

An individual who loses coverage as a result of termination for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) does not have the right to make application for coverage during the Special Enrollment Period.

Section II – Eligibility and Enrollment (Continued)

E. Special Circumstances

An Eligible Employee may apply for coverage due to the following special circumstances:

1. birth of a child;
2. Placement for adoption; or
3. marriage.

Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete and submit the Application for Group Insurance/Membership form through the Employer to Companion Life. The Eligible Employee must make application for enrollment within 30 days of the special circumstance. The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) who are enrolled as a result of birth, Adoption, Placement for Adoption, or marriage is the date of the event. Any Pre-existing Condition exclusionary period will not apply to a newborn child or Adopted child.

Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period. (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee.)

Section III - Effective Date of Insurance

A. Effective Date

1. Employee

An Employee's insurance under this Policy begins on the [XXth of the month that coincides with or next follows the] latest of the following dates:

- a) the date the Employee becomes eligible;
- b) the date the Employee enrolls in writing, if required;
- c) the date the Employee agrees to make any required premium contribution;
- d) the date Companion Life approves any required Evidence of Insurability for the Employee.

However, if the Employee is not Actively at Work on the date his or her insurance otherwise would begin, his or her insurance will not begin on that date but will instead begin on the first day the Employee is again Actively at Work.

2. Dependent

A Dependent's insurance under this Policy begins on the [XXth of the month that coincides with or next follows the] latest of the following dates:

- a) the date the Employee's insurance for himself or herself begins;
- b) the date the Employee enrolls for insurance for that Dependent in writing, if required;
- c) the date the Employee agrees to make any required premium contribution for that Dependent's insurance;
- d) the date Companion Life approves any required Evidence of Insurability for that Dependent.

However, if the Dependent is confined at home or in a Hospital or other facility on the date his or her insurance otherwise would begin, or is unable to engage in all the normal activities of a person in good health of like age and sex on that date, his or her insurance will not begin on that date but will instead begin on first date the Dependent both: (1) is no longer so confined; and (2) is able to engage in all the normal activities of a person in good health of like age and sex.

Section III - Effective Date of Insurance (Continued)

3. Changes in Benefits

Any change in benefits under this Policy applies with respect to any Insured Employee or Insured Dependent on the effective date of the Policy amendment to provide the change in benefits. However, with respect to any change that is an enhancement, improvement, or increase in benefits:

- a) if an Insured Employee is not Actively at Work on that day, the change will not apply with respect to that Employee until the first day he or she again is Actively at Work.
- b) if an Insured Dependent is confined at home or in a Hospital or other facility on that day, or is unable to engage in all the normal activities of a person in good health of like age and sex on that day, the change will not apply with respect to that Dependent until the first day the Dependent both: (1) is no longer so confined; and (2) is able to engage in all the normal activities of a person in good health of like age and sex.

B. Minimum Participation Requirements

For this Policy to remain in effect, the following minimum participation requirements must be satisfied:

1. Contributory Coverage

For Contributory Employee insurance, the Employer is required to maintain a minimum participation of [seventy-five percent (75%)] of eligible Employees not covered elsewhere. For Contributory Dependent insurance, the Employer is required to maintain a minimum participation of [seventy-five percent (75%)] of those eligible Employees not covered elsewhere with one or more eligible Dependents.

2. Non-Contributory Coverage

For Non-Contributory Employee insurance, the Employer is required to maintain a minimum participation of one hundred percent (100%) of eligible Employees. For Non-Contributory Dependent insurance, the Employer is required to maintain a minimum participation of one hundred percent (100%) of those eligible Employees with one or more eligible Dependents.

Failure to maintain the minimum participation requirements as described in (1) and (2) above will cause this Policy to terminate.

C. Additional Insured Persons

Additional Employees and Dependents may from time to time be added to the group originally insured when:

1. an Employee becomes eligible for insurance according to the provisions herein; and/or
2. a Dependent becomes eligible for insurance according to the provision herein.

Section IV – Covered Expenses

Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of this Plan of Benefits and the Schedule of Benefits. The total amount paid for Benefits shall not exceed the Lifetime Maximum and in the event that a Covered Person reaches the Lifetime Maximum, no further Benefits will be paid under this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will only be paid for Benefits:

1. Performed or provided on or after the Covered Person's Effective Date; and
2. Performed or provided prior to termination of coverage; and
3. Provided by a Physician, within the scope of his or her license; and
4. For which the appropriate Preadmission Review, Emergency Admission Review, Pre-Certification and/or Continued Stay Review has been requested and Pre-Certification was received from the Company; and
5. That are Medically Necessary; and
6. That are not subject to an exclusion under Section VII; and
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

Assignment of Covered Expenses

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

Specific Covered Benefits

If all of the following requirements are met the Company will provide the Benefits described and listed under Benefits of Section IV.

1. All of the requirements of this Section IV must be met.
2. The Benefit must be listed in this Section IV.
3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits.
4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits.
5. The Benefit must not be subject to one or more of the exclusions set forth in Section VII.

Section IV – Covered Expenses (Continued)

Benefits

Allergy Injections

The Company will pay Covered Expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,
2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) dose; and,
3. When any of the following conditions are met:
 - a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,
 - b. The patient has a life threatening allergy to insect stings; or,
 - c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,
 - d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

Ambulance

The Company will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:

1. Locally to or from a Hospital providing Medically Necessary service in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,
2. To or from a Hospital in connection with an Admission.

Chiropractic Services

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a “Non-Covered” notation, the Company will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Cleft Lip or Palate

The Company will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;
2. Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Prosthodontia treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and
7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Pre-Certified. If a Covered Person with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan of Benefits. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.

Colorectal Cancer Screening

The Company will pay Covered Expenses for a colorectal cancer screening regardless of Medical Necessity as outlined on the Schedule of Benefits. The Company will pay Covered Expenses for additional colorectal cancer screenings during a Benefit Year based on Medical Necessity.

Contraceptives

Coverage shall be provided for prescription contraceptive drugs or devices, including oral contraceptive and devices (IUD); subdermal contraceptive implants (Norplant) and related Treatments, Services and Supplies. Covered Expenses include the insertion or removal of and any Medically Necessary examination associated with the use of the prescribed contraceptive drug or device.

Dental Care for Accidental Injury

The Company will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Covered Person is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Certification; however, the dentist must submit a plan for any future treatment to the Company for review and Pre-Certification before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Diabetes Self-Management and Supplies

The Company will pay Covered Expenses for outpatient self-management training and education for Covered Persons with diabetes mellitus provided that such training and educational Benefits are rendered by a Physician whose program is recognized by the American Diabetes Association.

Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for an individual that meets the conditions specified in the plan. A Covered Person who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

Benefits will be paid for Covered Expenses incurred by a Covered Person for Medically Necessary equipment and related supplies for the treatment of diabetes when prescribed by a Doctor or other licensed health care provider.

Equipment and related supplies which may be Medically Necessary include, but are not limited to, the following:

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Diabetes data management systems for management of blood glucose;
4. Insulin pumps and equipment for the use of the pump including batteries;
5. Insulin infusion pumps; and
6. Podiatric appliances and therapeutic footwear.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a licensed Doctor.

Disease Management Program

The Company will offer Covered Persons who have an appropriate diagnosis the option to participate in the Company's Disease Management Program. A Covered Person's participation in the Disease Management Program is voluntary.

Durable Medical Equipment

The Company will pay Covered Expenses for standard, non-luxury (as determined by the Company) Durable Medical Equipment. The Company will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Company will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Covered Person in a Hospital or that the Company determines is included in any Hospital room charge.

Emergency Medical Care

The Company will pay Covered Expenses for health care items and services furnished or required to screen or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Gynecological Examination

The Company will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Covered Persons.

Health Questions Hotline

The Company will provide Covered Persons with access to a 24 hour, health care questions hotline.

Home Health Care

The Company will pay Covered Expenses for Pre-Certified Home Health Care, including private duty nursing, when rendered to a homebound Covered Person in the Covered Person's current place of residence.

Hospice Care

The Company will pay Covered Expenses for Pre-Certified Hospice Care.

Hospital and Skilled Nursing Facility Services

The Company will pay Covered Expenses for Admissions as follows:

1. Semiprivate room, board, and general nursing care;
2. Private room, at semi-private rate as determined by the Company;
3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;
4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
6. In a Long-Term Acute Care Hospital.

Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Covered Person leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Covered Person returns to the Hospital or Skilled Nursing Facility by midnight of the same day. The day a Covered Person enters a Hospital or Skilled Nursing Facility is treated as a day of Admission. The days during which a Covered Person is not physically present for inpatient care are not counted as Admission days.

Human Organ and Tissue Transplants

1. The Company will pay Covered Expenses for certain Pre-Certified human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Covered Person, and provided at a transplant center approved by the Company. Covered Expenses shall only be provided for the human organ and tissue transplants set forth on the Schedule of Benefits.
2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:

Section IV – Covered Expenses (Continued)

Benefits (Continued)

- a. When both the transplant recipient and the donor are Covered Persons, Covered Expenses will be paid for both.
 - b. When the transplant recipient is a Covered Person and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
 - c. When the donor is a Covered Person and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.
3. Benefits for human organ and tissue transplants are subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.
 4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.
 5. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under this Plan of Benefits, subject to all of the provisions of this Plan of Benefits as follows:
 - a. Blood transfusions;
 - b. Autologous parathyroid transplants;
 - c. Corneal transplants;
 - d. Bone and cartilage grafting; and
 - e. Skin grafting.

In-Hospital Medical Service

The Company will pay Covered Expenses for a Physician's visit or visits to a Covered Person during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-hospital medical Benefits primarily for Mental Health Services, Mental Health Conditions and Substance Abuse Services;
2. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.
3. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

4. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:
 - a. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant;
 - b. When the surgical procedure performed is designated by the Company as a warranted diagnostic procedure or as a minor surgical procedure.

When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

Mammography Testing

The Company will pay Covered Expenses for mammography testing as set forth on the Schedule of Benefits.

Maternity Management Program

The Company will provide Covered Persons with access to the Maternity Management Program. The Maternity Management Program is designed to assist a Covered Person in receiving prenatal care through coordination with the Covered Person, the Physician, and the Company. The Maternity Management Program is not provided for a Child.

Medical Supplies

The Company will pay Covered Expenses for Medical Supplies, provided that the Company will not pay Covered Expenses separately for Medical Supplies that are provided as part of another Benefit.

Mental Health Conditions

The Company will pay Covered Expenses for Mental Health Conditions.

Mental Health Services

The Company will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

Obstetrical Services

The Company will pay Covered Expenses for Pre-Certified obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Covered Person who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Under the terms of the Newborn and Mother’s Health Act of 1996, the Company generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother’s or newborn’s attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. . In any case, the Company may not require that a Physician obtain certification from the Company for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Certification is required to use certain Physicians or facilities, or to reduce out-of-pocket costs.

Online Health Assessment Program

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a “Non-Covered” notation the Company will provide Covered Persons with access to an online, internet based 24 hour, health care assessment service program.

Orthopedic Devices

The Company will pay Covered Expenses for Pre-Certification Orthopedic Devices.

Orthotic Devices

The Company will pay Covered Expenses for Pre-Certified Orthotic Devices that are not available on an over-the-counter basis.

Outpatient Hospital and Ambulatory Surgical Center Services

The Company will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

Outpatient Rehabilitation Services

The Company will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

Oxygen

The Company will pay Covered Expenses for Pre-Certified oxygen. Durable Medical Equipment for oxygen use in a Member’s home is covered under the Durable Medical Equipment Benefit.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Pap Smear

The Company will pay Covered Expenses for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Company will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

Physical Examination

The Company will pay Covered Expenses for an annual physical examination each Benefit Year for Covered Persons that are within the appropriate age guidelines regardless of Medically Necessity.

Physician Services

The Company will pay Covered Expenses for Physician Services, provided that when different levels (as determined by the Company) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Company) of Physician Services.

Prescription Drugs

1. The Company will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Company. Copayments likewise do not change due to receipt of any Credits by the Company.
2. If a Physician prescribes a Brand Name Drug and an equivalent Generic Drug is available (whether or not the Physician indicates in the prescription that the substitution of a Generic Drug is not allowed), any difference between the cost of a Generic Drug and the higher cost of a Brand Name Drug shall be the responsibility of the Covered Person.
3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

The Company may, in its sole discretion, place quantity limits on Prescription Drugs.

Prostate Examination

The Company will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Covered Persons that are within the appropriate age guidelines. The Company will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Prosthetic Devices

The Company will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Company) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Covered Person's condition warrants replacement.

Reconstructive Surgery Following Mastectomies

In the case of a Covered Person who is receiving Covered Expenses in connection with a mastectomy; the Company will pay Covered Expenses for each of the following (if requested by such Covered Person):

1. Reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema; in a manner determined in consultation with the attending physician and patient.
4. In addition, the Company will pay Covered Expenses for a minimum of 48 hours of inpatient care following mastectomy, unless a decision of early discharge is made by the attending health care provider and the patient.

Rehabilitation

The Company will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a medical doctor; and
2. All such treatment requires Pre-Certification and must be performed by a Physician and at a location designated by the Company; and
3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Covered Person evaluation from a medical doctor that documents that to a degree of medical certainty the Covered Person has rehabilitation potential such that there is an expectation that the Covered Person will achieve an ability to provide self care and perform activities of daily living; and
5. All such rehabilitation Benefits are subject to periodic review by the Company.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Covered Person is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

Routine Annual Benefits

The Company may offer certain routine annual Benefits (typically preventive care) as set forth on the Schedule of Benefits.

Specialty Drugs

The Company will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Covered Person shall not exceed the quantity and benefit maximum set by the Company. Specialty Drugs are medical Benefits. Any medical Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit Maximum will apply as set forth on the Schedule of Benefits. The Covered Person may obtain a list of Specialty Drugs by contacting the Company at the number listed on the Identification Card.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Company. Copayments likewise do not change due to receipt of any Credits by the Company.

Substance Abuse Services

The Company will pay Covered Expenses for Substance Abuse Services as set forth on the Schedule of Benefits.

Surgical Services

The Company will pay Covered Expenses for Surgical Services performed by a medical doctor or oral surgeon for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:
 - a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
 - b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

- c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.
 - d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.
 - e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Company when so requested by the medical doctor or oral surgeon in charge of the case.
 - f. Certain surgical procedures are designated as separate procedures by the Company, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.
2. Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Company will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.
 3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

Section IV – Covered Expenses (Continued)

Benefits (Continued)

State Mandated Benefits

The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Year Maximum Benefit amounts shown on the Schedule of Benefits.

Alcohol and Drug Abuse

The Company shall pay expenses for the treatment of alcoholism, chemical dependency or drug addiction when treatment is rendered in: (1) a licensed Hospital; (2) a residential treatment program as licensed by the state of Arkansas pursuant to diagnosis or recommendation by a Doctor of medicine, or (3) a nonresidential treatment program approved or licensed by the state of Arkansas.

Coverage for treatment in a licensed Hospital or residential treatment program shall be limited to 28 days in a policy year. Coverage for treatment in a nonresidential treatment program shall be limited to 130 hours of treatment in a policy year. Notwithstanding anything in this certificate to the contrary, coverage for expenses incurred due to alcohol or drug abuse will be covered the same as any other Sickness.

Dental Hospitalization

The Company will pay Covered Expenses for Hospital, ancillary, and general anesthesia services when rendered in a hospital, outpatient surgical facility, and for associated hospital or facility charges for dental care provided to a dependent child who is under age 5. Such dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:

1. The child has a physical, mental, or medically compromising condition; or
2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
3. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
4. The child has sustained extensive orofacial and dental trauma.

In Vitro Fertilization

Coverage is provided for expenses that arise from in vitro fertilization procedures.

Benefits for in vitro fertilization procedures shall be provided to the same extent as benefits provided for other pregnancy-related procedures under the policy.

Coverage for vitro fertilization procedures shall be provided only if:

1. The patient for the in vitro fertilization procedure is a Covered Person under the policy;
2. The fertilization or attempted fertilization of the Covered Person's oocytes is made only with the sperm of the Covered Person's spouse;
3. The Covered Person and the Covered Person's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

Section IV – Covered Expenses (Continued)

State Mandated Benefits (Continued)

4. The Covered Person has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy; and
5. The in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

Maternity Care

The Company will Pay Covered Expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, to the extent shown in the Schedule of Benefits, Certain maternity testing may not be covered under the Policy. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Policy are met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24 - 28 weeks gestation), one ultrasound (subsequent ultrasounds only if they are ordered by a Doctor as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity), and for a Covered Person over age 35, AFP Blood Screening, Amniocentesis/AFP Screening, Chromosome Testing, Fetal Stress/Non-Stress tests. Pre-natal vitamins are not covered.

Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
- b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

PKU Formula

The Company will pay Covered Expenses for nutritional supplements when Medically Necessary, as defined in Section I of this Policy, and when under the direction of a physician on an outpatient basis, either orally or through a tube, for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria.

Speech or Hearing Impairment

The Company will pay benefits for charges for the medically necessary care and treatment of loss or impairment of speech, language or hearing, as well as services performed by a speech and the participant.

Section V – Managed Care

Health Care Coordination

Health care coordination is a program under the Policy conducted by the Case Coordinator which is designated by Us who:

1. identifies cases involving the Covered Person in a clinical situation with the potential for catastrophic claims;
2. assesses such for the appropriateness of the level of patient care and the setting in which it is received;
3. develops, introduces and implements viable Alternate Treatment Plans for such cases that maintain or enhance the quality of patient care;
4. maximizes benefits through implementation of the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Case Coordinator through discussion and agreement with the legal age Covered Person or legal guardian (if necessary), the Physician and Us. It includes:

1. treatment plan objectives;
2. course of treatment planned to accomplish such objectives;
3. responsibility of each party (Case Coordinator, attending Physician and Covered Person and his/her family, if any) in implementing the plan;
4. estimated cost and savings.

If We agree with the Case Coordinator, the attending Physician and the Covered Person on an Alternate Treatment Plan, We may pay incurred Covered Charges at a higher percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Covered Charges under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall be contingent upon written approval by Us or Our authorized Administrator. If such written approval is granted, payment of benefits under the Policy for such services or supplies shall be on the same basis as if such services or supplies were Covered Charges under the terms and provisions of the Policy.

NO COVERED PERSON IS REQUIRED, IN ANY WAY WHATSOEVER, TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE CASE COORDINATOR.

Section VI - Pre-Certification Program

The Pre-Certification Program is applicable to all Inpatient Confinements at a Hospital or Skilled Nursing Facility and any Covered Charges incurred in connection with such Confinement. The Pre-Certification Program also applies to Hospice Confinements and Home Health Care services received, and any Covered Charges incurred in connection with Complications of Pregnancy.

Pre-Certification of Non-Emergency Services

To request Pre-Certification, the Covered Person or the Covered Person's attending Physician must contact the Pre-Certification Service at least seven (7) days in advance. The Pre-Certification Service can be reached by writing or by telephone during normal business hours each business day. The name of the Pre-Certification Service and instructions are provided to each Covered Person.

The Covered Person will be requested to provide:

1. name, address and the telephone number of the attending Physician ;
2. the proposed treatment plan;
3. the Covered Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Certification Service will then consult with the Covered Person's attending Physician. If the Pre-Certification Service concurs with the Covered Person's Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, he or she will so certify in writing to the Covered Person and the Covered Person will be deemed to have complied with the Pre-Certification requirement described herein.

The Pre-Certification Service may also provide a Continued Stay Review. The Continued Stay Review is a process of monitoring a patient's progress on a daily basis to determine if the patient will be discharged within the pre-certified number of days, and to determine the appropriate number of additional days of stay that may be required according to the patient's condition and plan of treatment. All Hospital admissions will be monitored to assure that patients will be discharged on time. The admitting and/or attending Physician(s) and the Hospital utilization review Nurses will be contacted to determine the progress of the patient and the need, if any, for an extension of certified Hospital days. If an extension of the stay is not certified for all or part of the requested day(s), the Covered Person and the admitting and/or attending Physician(s) will be notified.

In absence of Pre-Certification, benefits are subject to Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

No benefits will be paid for Covered Charges incurred for any such Confinement or treatment plan which extends beyond the number of days deemed by the Pre-Certification Service to be Medically Necessary.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

IF THE PRE-CERTIFICATION SERVICE DOES NOT CONCUR WITH THE COVERED PERSON'S PHYSICIAN, THE PRE-CERTIFICATION SERVICE WILL SO NOTIFY THE COVERED PERSON IN WRITING AND THE COVERED PERSON WILL NOT BE DEEMED TO BE IN COMPLIANCE WITH THE PRE-CERTIFICATION REQUIREMENT DESCRIBED HEREIN AND THE FAILURE TO PRE-CERTIFY DEDUCTIBLE WILL APPLY.

Section VI - Pre-Certification Program (Continued)

Pre-Certification of Emergency Care

Emergency Inpatient Confinements must be certified in the same manner as a non-emergency Inpatient Confinement, but the Covered Person or the Covered Person's Physician must contact the Pre-Certification Service within forty-eight (48) hours (or as soon as reasonably possible) of the Emergency Inpatient Confinement. The attending Physician must verify that an Emergency condition existed. In absence of Pre-Certification, benefits are subject to the Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Policy.

Pre-Certification for Complications of Pregnancy and Case Coordination

We require notice to the Pre-Certification Service of Complications of Pregnancy within seven (7) days from the date the Covered Person first obtains such diagnosis.

The Pre-Certification Service can be reached by writing or by telephone during normal business hours each business day. The name of the Pre-Certification Service and instructions are provided to each Covered Person. The Covered Person will be requested to provide:

1. name, address, and the telephone number of the attending Physician (if any);
2. the Covered Person's authorization (or, if a minor, authorization on his or her behalf) to release medical information;

The Pre-Certification Service may then refer the Covered Person or the attending Physician to the Pregnancy Case Coordination Coverage Program which:

1. may help to identify and monitor a Covered Person who is at high risk for premature delivery, or have Pregnancy-induced hypertension;
2. explores appropriate, cost-effective alternatives to lengthy hospitalizations before delivery for high risk mothers; encourages the pregnant Covered Person and newborn in staying healthy through prenatal education.

In the absence of Pre-Certification, benefits are subject to the Failure to Pre-Certify Deductibles as shown in the Schedule of Benefits.

Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of this coverage.

Failure to Pre-Certify Deductibles

If the Covered Person complies with the Pre-Certification requirement, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits per Hospital Confinement, Skilled Nursing Facility Confinement, Hospice Confinement, or for Home Health Care, will be waived by Us.

If the Covered Person complies with the Pre-Certification requirement for Complications of Pregnancy, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits for such Complications of Pregnancy will be waived by Us. In the event the Covered Person does NOT comply with Pre-Certification, the Failure to Pre-Certify Deductible amount as shown in the Schedule of Benefits will apply only once per Complications of Pregnancy including any Inpatient Confinement in connection with the Pregnancy.

Section VI - Pre-Certification Program (Continued)

This Deductible does not accumulate toward the Calendar Year Deductible amounts or the Individual Out-of-Pocket Maximum amounts.

Pre-Certification Program Appeal Mechanism

The Pre-Certification Program is administered with a built-in appeal process. Issues which are not resolved by the attending Physician and the medical review specialist during the initial evaluation are elevated within the Pre-Certification Service's review program to ensure that the Covered Person's attending Physician has the opportunity to discuss the case with other qualified medical personnel. Prompt attention is given by the Pre-Certification Service to ensure that additional resources are available to work directly with the attending Physician to evaluate the proposed treatment and provide every opportunity to reach an accord.

We do not arrange or provide for the provision of health care services or supplies. It is always the Covered Person's responsibility to select a health care Provider of their choice. We have no control and are not responsible for the actions or lack of actions of any Provider organization pertaining to any medical services rendered to a Covered Person.

Section VII – Exclusions and Limitations

No benefits shall be payable under the Policy for:

1. Expenses incurred by or for a Covered Person in connection with a Pre-Existing Condition as defined in Section I – Definitions, for twelve (12) months after the effective date as shown on the Policy cover page for that Covered Person. No claim for Covered Charges incurred more than twelve (12) months after a Covered Person's effective date will be reduced or denied solely on the grounds that the charge is due to a Pre-Existing Condition, unless the condition is excluded or limited by name or specific description in an amendatory endorsement that is attached to the Policy. This limitation shall not apply to a Dependent child who is adopted or placed for adoption before age eighteen (18), however, expenses incurred before adoption or placement for adoption will not be covered.
2. Any Confinement, treatment, service, supply or prescription which is: (a) not necessitated by a Bodily Injury or Sickness, (b) not authorized by a Physician; (c) not Medically Necessary; (d) not Necessary, Reasonable, and Customary; or (e) not incurred while this coverage is in force.
3. Experimental or Investigational medical treatment as defined in Section I - Definitions.
4. Voluntary abortions.
5. Bodily Injury or Sickness which arises out of or in the course of any employment for wage or profit, nor for a Bodily Injury or Sickness for which the Covered Person has or had a right to compensation under any Workers' Compensation law or occupational disease law, unless specifically amended by the 24-Hour Occupational Coverage Rider attached hereto.
6. Any Confinement, treatment, service or supply provided by a government owned or operated facility, unless the Covered Person is legally required to pay the charges incurred.
7. Bodily Injury or Sickness resulting from war or any act of war (declared or undeclared).
8. Charges incurred while on active duty with any military, naval or air force of any country or international organization.
9. Services and supplies for treatment of: (a) the teeth; and (b) the gums other than for tumors; and (c) any other associated structures primarily in connection with the treatment or replacement of natural teeth; and (d) prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, unless due to an Injury which occurs while covered under the Policy to Natural Teeth, provided that such treatment is received within ninety (90) days following the date of injury.
10. Treatment or surgery as the result of prognathism, retrognathism, micrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an Injury, which occurs while covered under the Policy to Natural Teeth, provided that such treatment is received within ninety (90) days following the date of Injury.
11. Services or supplies to improve the appearance or self perception of a Covered Person, which does not restore a bodily function, including without limitation; cosmetic or plastic surgery, hair loss; or skin wrinkling.

Section VII – Exclusions and Limitations (Continued)

12. Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery.
13. Hearing aids or the fitting thereof.
14. Charges incurred as a result of participation in a riot or insurrection or the commission of a felony or while imprisoned.
15. Charges for radial keratotomy and radial keratectomy or other similar procedures, including laser based procedures, that are performed on the eyes.
16. Meridian therapy (acupuncture), except when used in lieu of an anesthetic.
17. Routine physical examinations, immunizations, use of prophylactic injections including gammaglobulins and flu shots, and the well-child care including immunizations, unless covered by the Optional Wellness Benefit Rider.
18. Charges for treatment, paring or removal of corns, calluses or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending Physician who is treating the Covered Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis, or treatment of the feet by posting or strapping, or range of motion studies, or orthotics.
19. Treatments made in connection with obesity or weight reduction including wiring of the teeth and all forms of intestinal bypass surgery.
20. Charges for services rendered by a Physician, Nurse or other provider if such person: (a) is a Close Relative of the Covered Person's or (b) lives in the same household as the Covered Person, or (c) is the Employer of the Covered Person, except for charges rendered while a Hospital Inpatient.
21. Charges incurred as the result of attempted suicide or intentionally self-inflicted Bodily Injury or Sickness while sane or insane.
22. Treatment for Mental, Nervous or Chemical Dependency Disorders, except as limited in Section IV – Covered Expenses.
23. Charges related to or in connection with: (a) procedures to restore or enhance fertility; and (b) reversal of sterilization; (c) penile implants; and (d) fertility and sterility studies.
24. Hospital and Physician charges for weekend Hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day.
25. Congenital conditions, except with respect to children covered from birth.
26. Sexual reassignments or sexual dysfunctions or inadequacies.
27. Custodial Care, regardless of whom prescribes or renders such care.
28. Services or supplies for which no charge is made or for which the Covered Person is not required to pay.
29. Services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or for pleasure not to exceed 90 days, provided the procedure or treatment is approved for use in the United States.
30. Charges related to or in connection with Human Organ or Tissue Transplants or high dose chemotherapy administered in connection therewith except if provided under Section IV – Covered Expenses.

Section VII – Exclusions and Limitations (Continued)

31. Charges related to Outpatient prescription drugs, except if the Outpatient Prescription Medication Card Benefit Rider is shown in the Schedule of Benefits.
32. Any education or training materials including, but not limited to: pain management; the management of asthma, heart disorders and other medical disorders; pre-natal screening education, unless such programs or materials are offered through Our Health Care Coordination in conjunction with a disease management program.
33. Equipment, other than Durable Medical Equipment, including, but not limited to: modifications to motor vehicles or homes such as to wheelchair lifts or ramps; water therapy device, such as whirlpools or hot tubs; and exercise equipment.
34. Any service or supply to eliminate or reduce a dependency or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism or goal oriented behavioral modification.
35. Any surgical removal of an organ or tissue unless Medically Necessary.
36. Treatment for Home Health Care Services, except as provided in Section IV – Covered Expenses.
37. Treatment for Hospice Care Services, except as limited in Section IV – Covered Expenses.
38. Non-Surgical Back Treatment, except as limited in Section IV – Covered Expenses.
39. Any service or supply in connection with the implant of an artificial organ, including the implant of an artificial organ.
40. Personal convenience services or supplies including without limitation: beauty or barber services; radio and television; non therapeutic massages; telephone charges; take home supplies and guest meals; and motel accommodations.
41. Any non-prescriptive medication.
42. Charges for voice training for a lisp.
43. Breast reduction surgery unless such surgery was performed as part of a mastectomy due to breast cancer.

Section VIII - Cancellation, Termination and Renewal

1. Companion Life may cancel this Policy at any time, after the first policy anniversary, by written notice delivered to the Employer, stating when, not less than thirty-one (31) days thereafter, the cancellation shall take effect. The Employer may cancel this Policy at any time by written notice to Companion Life, with the cancellation to be effective on the later of: (1) Companion Life's receipt of the notice; or (2) the date specified in the notice. Cancellation shall be without prejudice to any Claim originating prior to the Effective Date of cancellation
2. This Policy will be renewed on a year-to-year basis unless canceled pursuant to the above paragraph or unless terminated pursuant to the following paragraphs of this Section.
3. Termination of a Covered Employee's Coverage. A Covered's Employee's coverage will automatically terminate at 12:01 a.m.:
 - a. on the date this Policy terminates;
 - b. on the last day of the first month that the Covered Employee fails to continue to meet any of the applicable eligibility requirements;
 - c. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause section); or
 - d. on the date the Employee's active employment with the Employer ends, except with respect to any continuation mandated pursuant to state or federal law.
4. Termination of a Covered Dependents' Coverage. A Covered's Dependent's coverage will automatically terminate at 12:01 a.m.:
 - a. on the date this Policy terminates;
 - b. on the date the Covered Employee's coverage terminates for any reason;
 - c. on the last date of the month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee);
 - d. on the date specified by the Employer that the Covered Dependent's coverage is terminated by the Employer for cause; or
 - e. on the dated specified by the Employer that the Covered Dependent's coverage terminated.
5. Termination of an Individual's Coverage for Cause. In the event any of the following occurs, the Employer may terminate an individual's coverage for cause:
 - a. fraud, intentional misrepresentation of material fact, or omission in applying for coverage of benefits;
 - b. the knowing misrepresentation, omission, or the giving of false information on the Application for Group Insurance/Membership, Member Status Change Request Form, or other forms completed, by or on behalf of the Covered Plan Participant;
 - c. misuse of the Identification Card.
6. Notice of Termination to Covered Plan Participants – It is the Employer's responsibility to immediately notify Covered Plan Participants of termination of this Policy for any reason.

Section VIII - Cancellation, Termination and Renewal (Continued)

7. Certification of Creditable Coverage – In the event coverage terminates for any reason, a written Certification of Creditable Coverage to the Covered Plan Participant will be issued. The Certification of Coverage will indicate the period of time the Covered Plan Participant was covered under this Policy. Creditable Coverage may reduce the length of any Pre-existing condition exclusion period by the length of time the Covered Plan Participant had prior Creditable Coverage.

Covered Plan Participants may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if coverage under this Policy meets the qualifying creditable coverage guidelines (e.g., no more than a 63-day break in coverage).

Section IX - Continuation Coverage

Any employee insured in this state under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for a least three months under this Contract, or this and its immediately preceding health insurance contract, you may elect to continue group health coverage for yourself and your enrolled family members for the rest of the month of termination and four additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently.

Cost – These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the company's Group Health Benefit Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- your employment is terminated for cause; or
- your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- your health plan enrollment is terminated and replaced without interruption by another group contract; or
- health insurance is terminated for the entire class of Employees to which you belong; or
- the Group terminates health insurance for all Employees.

Termination of Benefits – Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other group insurance or Medicare.

Conversion – Conversion rights during the continuation period are the same as for insured Employees. If the Group terminates its health insurance Contract during an Employee's continuation period, the Plan Administrator must notify continuing Employees that conversion rights must be exercised within 31 days.

Section X – Continuing Coverage Under Cobra

If you or your Eligible Dependents lose health coverage under the Master Group Policy as a result of a Qualifying Event, you may be entitled to extend coverage for a period of time under federal legislation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, Domestic Partners and Eligible Dependents of Domestic Partners do not qualify for COBRA coverage.

Qualifying Events – COBRA continuation coverage may be elected if coverage under this Group Health Policy ends due to one or more of the following “Qualifying Events”:

- Your employment ends (except for termination due to gross misconduct or fraud); or
- Your work hours are reduced; or
- You become entitled to Medicare benefits; or
- Your death; or
- Divorce or legal separation; or
- Loss of dependent eligibility; or
- If You are a covered retiree, filing a proceeding in bankruptcy under Title 11 of the United States Code.

If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree’s death.

Continuation Period – Coverage may be continued under COBRA for up to the maximum period of time specified below. The length of time depends on the Qualifying Event(s) and circumstances.

18-Month Continuation Period. If You lose coverage due to termination of Your employment for any reason (other than gross misconduct), or due to reduced work hours, You may continue coverage for Yourself and Your Eligible Dependents for up to eighteen (18) months following the termination or work reduction date.

29-Month Continuation Period. If the Social Security Administration (SSA) determines that You are disabled at any time during the first sixty (60) days of continued coverage, and the Qualifying Event for continued coverage was termination of employment or a reduction in work hours, You may extend COBRA coverage by an additional eleven (11) months, for a total of twenty-nine (29) months of coverage subject to the certain conditions:

- You must notify the Policyholder’s plan administrator of the disability within sixty (60) days of the SSA determination and before the end of the original eighteen (18) month COBRA continuation period; and
- You must agree to pay any increase in the required payment necessary to continue the coverage for the additional eleven (11) months.
- If You have any non-disabled Covered Dependents entitled to COBRA, they are also entitled to extend COBRA coverage by an additional eleven (11) months of coverage.

Section X – Continuing Coverage Under Cobra (Continued)

36-Month Continuation Period. Coverage may be continued for up to thirty-six (36) months from the date of coverage would have stopped due to a Qualified Event other than described above.

If a second Qualifying Event occurs within the original eighteen (18) month continuation period, coverage may be continued for a total of thirty-six (36) months from the date of the first Qualifying Event. Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Notification Requirements – You must notify Your Human Resources or Employee Benefits office in writing within sixty (60) days when either of the following Qualifying Events occur:

- Divorce or legal separation
- A child loses eligibility as a dependent

Your Human Resources or Employee Benefits office will send You the appropriate forms within fourteen (14) days after receiving Your notice.

Election Period – You have at least sixty (60) days to elect to continue coverage under COBRA. The election period ends on the later of:

- Sixty (60) days after the date coverage would have stopped due to a Qualifying Event; or
- Sixty (60) days after the date You receive notice of COBRA continuation rights.

Unless otherwise specified, You or Your spouse's election to continue will be considered an election on behalf of all other Covered Dependents who would also lose coverage because of the same Qualifying Event.

Required Payment – You are required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost charged for Employees with similar coverage, including both the portion paid by Employees and any portion paid by the Employer before the qualifying event, plus 2 percent for administrative costs.

If You are receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the Plan's total cost of coverage.

You have forty-five (45) days from the date of election to make the first required payment for COBRA continuation coverage. Payment must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum thirty (30) day grace period for payments. Payment is considered to be made on the date it is sent to the Plan.

Section X – Continuing Coverage Under Cobra (Continued)

Continued Coverage Ends – Continuation of coverage under COBRA will end for You or Your Eligible Dependents on the earliest of the following dates:

- The date Your maximum COBRA period ends.
- The date You fail to make the required payment for continued coverage within the thirty (30) day grace period.
- The date You become covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to You, You may continue COBRA coverage only until these limitations cease.
- For a spouse or dependent who was entitled to Medicare prior to a Qualifying Event due to termination of employment or reduction of work hours, eighteen (18) months after the Qualifying Event, or if later, thirty-Six (36) months from the date You become entitled to Medicare.
- The date the Master Group Policy terminates.

Section XI – Conversion Privilege

Eligibility Criteria for Conversion

A Covered Plan Participant may apply for an individual policy (hereinafter referred to as a “converted policy”) if the Covered Plan Participant’s coverage has been terminated for any reason, including discontinuance of this Policy in its entirety and termination of continued coverage under COBRA.

Companion Life will mail to a Covered Plan Participant, within 14 days after the Covered Plan Participant gives proper notice to Companion Life that he/she is considering applying for a converted policy of the Covered Plan Participant requests such information, a converted policy application and premium notice, including and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

Companion Life must receive a completed application for a converted policy and the applicable Premium payment within the 63-day period beginning on the date the coverage under this Policy terminated. If coverage has been terminated due to the non-payment of employee contribution by the Employer, Companion Life must receive the completed converted policy application and the applicable Premium payment within the 63-day period beginning on the date notice was given that the coverage terminated.

In the event Companion Life does not receive the converted policy application and the initial Premium payment with such 63-day period, the Covered Plan Participant’s converted policy application will be denied and the Covered Plan Participant will not be entitled to a converted policy.

Additionally, a Covered Plan Participant is not entitled to a converted policy if:

1. the Covered Plan Participant is eligible for or covered under the Medicare program;
2. the Covered Plan Participant’s coverage terminated because the Covered Employee failed to make any Premium contribution payment on a timely basis;
3. coverage was replaced by any group policy, contract, plan, or program, including self-insured plan or program, that provides benefits similar to the benefits provided under this Group Health Plan Description; or
4. a. the Covered Plan Participant is covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits similar to the benefits provided under this Policy; or
b. the Covered Plan Participant is eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Policy; or

Section XI – Conversion Privilege (Continued)

- c. benefits similar to the benefits provided under this Policy are provided for or are available to the Covered Plan Participant pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and
5. the benefits provided under the sources referred to in paragraph 4a. and c. above, together with the benefits provided by Companion Life’s converted policy would result in over insurance in accordance with Companion Life’s over insurance standards, as determined by Companion Life.

Neither the Employer nor Companion Life has any obligation to notify any Covered Plan Participant of this conversion privilege when the Covered Plan Participant’s coverage terminates or at any other time. It is the sole responsibility of the Covered Plan Participant to exercise this conversion privilege by submitting a Companion Life converted policy application and the initial Premium payment to Companion Life on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day the individual’s coverage hereunder terminated.

Note: Companion Life’s converted policies are not a continuation of coverage under COBRA or any other state’s similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Policy. A Covered Plan Participant applying for a Companion Life converted policy has two options:

- 1) a converted policy providing major medical coverage, and
- 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan. In any event, Companion Life shall not be required to issue a converted policy unless required to do so by applicable state law.

Section XII – Extension of Benefits

In the event this Policy is terminated, there is no coverage for any Health Care Service rendered on or after the termination date. The extension of benefits provision set forth below only apply when this Policy is terminated. The extension of benefits provided hereunder do not apply when an individual Covered Plan Participant's terminates as long as this Policy remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is the Covered Plan Participant's responsibility to provide acceptable documentation to Companion Life that the Covered Plan Participant is entitled to an extension of benefits.

1. In the event a Covered Plan Participant is Totally Disabled on the termination date of this Policy as a result of a specific Accident or illness incurred while the Covered Plan Participant was covered under this Policy, Companion Life will provide a limited extension of benefits for the disabled Covered Plan Participant only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted, however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of this Policy.

For purposes of this section, a person is "Totally Disabled" only if, in the opinion of Companion Life, the Covered Plan Participant is unable to work at any gainful job for which the Covered Plan Participant is suited by education, training, or experience. For those Covered Plan Participants who do not work (e.g., a student, child, or non-working spouse) such Covered Plan Participant is Totally Disabled only if in the opinion of Companion Life, the Covered Plan Participant is unable to perform those normal day-to-day activities which they would otherwise perform and such Covered Plan Participant requires regular care and attendance by a Physician.

2. In the event a Covered Plan Participant is receiving covered dental treatment as of the termination date of this Policy, Companion Life will provide a limited extension of benefits for such covered dental treatment provided:
 - a. a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while the Covered Plan Participant was covered under this Policy;
 - b. the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and

Section XII – Extension of Benefits (Continued)

- c. the dental procedures were performed within 90 days after the Covered Plan Participant's coverage terminated under this Policy, and the termination did not occur as a result of the Covered Employee's voluntary termination of coverage.

This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of this Policy or on the date the Covered Plan Participant becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or services for similar dental procedures. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

2. In the event a Covered Plan Participant is pregnant as of the termination date of this Group Health Plan, Companion Life will provide a limited extension of the maternity expense benefits provided by this Policy, provided the pregnancy commenced while the pregnant Covered Plan Participant was covered under this Policy, as determined by Companion Life. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

Section XIII – Claims Processing

Introduction

This section is intended to:

1. help the Covered Plan Participant understand what the Covered Plan Participant or the Covered Plan Participant's treating Providers must do, under the terms of this Policy, in order to obtain payment for expenses for Covered Services they have rendered or will render to the Covered Plan Participant;
2. provide the Covered Plan Participant with a general description of the applicable procedures that will be used for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the Covered Plan Participant when benefits are denied.

Under no circumstances will Companion Life be held responsible for, nor will Companion Life accept liability relating to, the failure of the Covered Plan Participant's Group Health Plan's sponsor or plan administrator to: 1) comply with any applicable disclosure requirements; 2) provide the Covered Plan Participant with a Summary Plan Description (SPD); or 3) comply with any other legal requirements. Covered Plan Participant should contact the plan sponsor or administrator with questions relating to the Group Plan's SPD. Companion Life is not the Covered Plan Participant's Group Health Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims - For the purpose of this Policy, there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that the Covered Plan Participant become familiar with the types of claims that can be submitted to Companion Life and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to Companion Life. PPO Providers have agreed to file Post-Service Claims for services rendered to a Covered Plan Participant. In the event a Provider who renders services to the Covered Plan Participant does not file a Post-Service Claims for such services, it is the Covered Plan Participant's responsibility to file it with Companion Life.

Companion Life must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if Companion Life does not receive it at the address indicated on the Covered Plan Participant's ID Card within one year of the date the service was rendered unless the Covered Plan Participant was legally incapacitated.

Section XIII – Claims Processing (Continued)

For a Post-Service Claim, Companion must receive an itemized statement from the health care Provider for the service rendered along with a completed claim form. The itemized statement must contain the following information:

1. the date the service was provided;
2. a description of the service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis codes(s);
5. the Provider's name and address;
6. the name of the individual who received the service; and
7. the Covered Employee's name and contract number as they appear on the ID Card.

The itemized statement and claim form must be received by Companion Life at the address indicated on the Covered Plan Participant's ID Card.

The Processing of Post-Service Claims

Companion Life will use its best efforts to pay, contest, or deny all Post-Service Claims for which Companion Life has all of the necessary information, as determined by Companion Life. Post-Service Claims will be paid, contested, or denied within the timeframes described below:

- Payment for Post-Service Claims

When payment is due under the terms of the Policy, Companion Life will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, Companion Life will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 45 days of receipt. The Covered Plan Participant may receive notice of payment for paper claims within 30 days of receipt. If Companion Life is unable to determine whether the claim or a portion of the claim is payable because more or additional information is needed, Companion Life may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

In the event Companion Life contests an electronically submitted Post-Service Claim, or a portion of such claim, Companion Life will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event Companion Life contests a Post-Service Claim submitted on a paper form, or a portion of such claim, Companion Life will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that

Section XIII – Claims Processing (Continued)

Companion Life reasonably expects to notify the Covered Plan Participant of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If Companion Life requests additional information, Companion Life must receive it within 45 days of the request for the information. If Companion Life does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of Companion Life at the time and may be denied. Upon receipt of the requested information, Companion Life will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- **Denial of Post-Service Claims**

In the event Companion Life denies a Post-Service Claims submitted electronically, Companion Life will use its best effort to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event Companion Life denies a paper Post-Service Claim, Companion will use its best effort to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Plan Participant's responsibility to ensure that Companion Life receives all information determined by Companion Life as necessary to adjudicate a Post-Service Claim. If Companion Life does not receive the necessary information, the claim or a portion of the claim may be denied.

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Determination standards and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

In the event, Companion Life will use its best effort to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by Companion Life or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by Companion Life within the applicable timeframe is subject to the payment of simple interest at the rate established by applicable Insurance Code.

Companion Life will investigate any allegation of improper billing by a Provider upon receipt of written notification from the Covered Plan Participant. If Companion Life determines that the Covered Plan Participant was billed for a service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due to solely to the notification from the Covered Plan Participant, Companion Life will pay the Covered Plan Participant 20 percent of the amount of the amount of the reduction, up to a total of \$500.

Pre-Service Claims

How to File A Pre-Service Claim

This Policy may condition coverage, benefits, or payment (in whole or in part), of a specific Covered Service, on the receipt by Companion Life of a Pre-Service Claim as that term is defined herein. In order to determine

Section XIII – Claims Processing (Continued)

whether Companion Life must receive a Pre-Service Claim for a particular Covered Service, please refer to the Covered Services section and other applicable sections of this Policy. The Covered Plan Participant may also call Companion Life's customer service number on the Covered Plan Participant's ID card for assistance.

Companion Life is not required to render an opinion or make a coverage or benefit determination with respect to a service that has not actually been provided to the Covered Plan Participant unless the terms of this Policy require (or condition payment upon) approval by Companion Life for the service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, Companion Life will use its best effort to provide notice of the determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, Companion Life will use its best effort to provide notice within 24 hours of: 1) the need for additional information; 2) the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) the date that Companion Life reasonably expects to provide notice of the decision. If Companion Life requests additional information, Companion Life must receive it within 48 hours of the request. Companion Life will use its best effort to provide notice of the decision on an Covered Plan Participant's Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period that was afforded to provide the specific additional information as described above.

Benefit Determinations on Pre-Service Claims That Do Not Involve Urgent Care

Companion Life will use its best efforts to provide notice of the decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. Companion Life may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, Companion Life will use its best effort to provide notice of the extension and reasons for it. Companion Life will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service claims within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by Companion Life.

If additional information is necessary to make a determination, Companion Life will use its best effort to: provide notice of the need for additional information prior to the expiration of the initial 15-day period; 2) identify the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) inform the Covered Plan Participant of the date that Companion Life reasonably expects to notify the Covered Plan Participant of the decision. If Companion Life requests additional information, Companion Life must receive it within 45 days of the request for the information. Companion Life will use its best effort to provide notification of the decision on an Covered Plan Participant's Pre-Service Claim within 15 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Determination standards and appeal procedures described in this section.

Section XIII – Claims Processing (Continued)

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for services will be considered an Adverse Benefit Determination when:

- Companion Life and/or the Employer has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of services; and
- the reduction or termination of coverage or benefits by Companion Life and/or the Employer was not due to an amendment of this Policy or termination of the Covered Plan Participant's coverage as provided by this Policy.

Companion Life will use its best efforts to notify the Covered Plan Participant of such reduction or termination in advance so that the Covered Plan Participant will have a reasonable amount of time to have the reduction or termination renewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event will Companion Life be required to provide more than a reasonable period of time within which the Covered Plan Participant may develop the appeal before Companion Life actually terminates or reduces coverage for the services.

Requests for Extension of Services

The Covered Plan Participant's Provider may request an extension of coverage or benefits for a service beyond the approved period of time or number of approved services. If the request for an extension is for a Claim Involving Urgent Care, Companion Life will use its best efforts to notify the Covered Plan Participant of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. Companion Life will use its best efforts to notify the Covered Plan Participant within 24 hours if: 1) additional information is needed; 2) the Covered Plan Participant or the Covered Plan Participant's representative failed to follow proper procedures in the request for an extension. If Companion Life and/or the Employer request additional information, the Covered Plan Participant will have 48 hours to provide the requested information. Companion Life may notify the Covered Plan Participant orally or in writing, unless the Covered Plan Participant or the Covered Plan Participant's representative specifically request that it be in writing. A denial of a request for extension of services is considered an Adverse Benefit Determination and is subject to the Adverse Determination review procedure below.

Section XIII – Claims Processing (Continued)

Standards For Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

Companion Life will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to the Covered Plan Participant free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Policy provisions which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If Covered Plan Participant's claim is a Claim Involving Urgent Care, Companion Life may notify the Covered Plan Participant orally within the proper timeframes, provided Companion Life follows-up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

How to Appeal an Adverse Benefit Determination

The Covered Plan Participant, or a representative designated by the Covered Plan Participant in writing, has the right to appeal an Adverse Benefit Determination. Companion Life will review the Covered Plan Participant's appeal through the review process described below. The Covered Plan Participant's appeal must be submitted in writing to Companion Life within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Covered Plan Participant to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations.

- Companion Life must receive the Covered Plan Participant's appeal of an Adverse Benefit Determination in person or in writing;
- The Covered Plan Participant may request to review pertinent documents, such as any internal rule guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, the Covered Plan Participant may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Policy to the Covered Plan Participant's medical circumstances.

Section XIII – Claims Processing (Continued)

- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;
- Companion Life may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews an Covered Plan Participant's Adverse Benefit Determination on behalf of Companion Life will be identified upon request; and
- If Covered Plan Participant's claim is a Claim Involving Urgent Care, the Covered Plan Participant may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between the Covered Plan Participant and Companion Life by telephone, facsimile or other available expeditious method.

Timing of Appeal Review on Adverse Benefit Determinations by Companion Life

Companion will use its best efforts to review a Covered Plan Participant's appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims – within 30 days of the receipt of the Covered Plan Participant's appeal; or
- Post-Service Claims - within 50 days of the receipt of the Covered Plan Participant's appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care services made within 24 hours prior to the termination of the services) – within 72 hours of receipt of the Covered Plan Participant's request. If additional information is necessary Companion Life notify the Covered Plan Participant within 24 hours and Companion Life must receive the requested information with 48 hours of the request. After Companion Life receives the additional information, Companion Life will have an additional 48 hours to make a final determination.

Note: The nature of a claim for services (i.e., whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the service was initially reviewed or provided.

The Covered Plan Participant, or a Provider acting on behalf of the Covered Plan Participant, who has a claim denied as not Medically Necessary has the opportunity to appeal the claim denial. The appeal may be directed to an employee of Companion Life who is a licensed Physician responsible for Medical Necessity reviews. The appeal may be by telephone and the Physician will respond to the Covered Plan Participant, within a reasonable time, not to exceed 15 business days.

Submit Appeals of Adverse Benefit Determinations to:

[Director of Claims
Companion Life Insurance Company
Post office Box 100102
Columbia, South Carolina 29202-3102
Fax (800) 836-5433]

Section XIII – Claims Processing (Continued)

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

In order to process claims, Companion Life and/or the Employer may need certain information, including information regarding other health care coverage the Covered Plan Participant may have. The Covered Plan Participant must cooperate with the Employer and/or Companion Life's effort to obtain such information by, among other ways, signing any release of information form at the request of Companion Life. Failure by the Covered Plan Participant to fully cooperate with Companion Life and/or the Employer may result in a denial of the pending claim.

2. Physical Examination:

In order to make coverage and benefit decisions, the Employer may, at its expense, require the Covered Plan Participant to be examined by a health care Provider of the Employer's choice as often as is reasonably necessary while a claim is pending. Failure by the Covered Plan Participant to fully cooperate with such examination shall result in a denial of the pending claim.

3. Legal Actions:

No legal action arising out of or in connection with coverage under this Policy may be brought against the Employer within the 60-day period following receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

Companion Life relies on information provided on the itemized statement and the claim form when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy Companion Life and/or the Employer may have, in denial of the claim or cancellation of rescission of the Covered Plan Participant's coverage.

5. Explanation of Benefits Form:

All claims decisions, including denial and claims review decisions, will be communicated to the Covered Plan Participant in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

- a. the specific reason or reasons for the Adverse Benefit Determination;
- b. reference to the specific Policy provisions which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

Section XIII – Claims Processing (Continued)

- c. a description of any additional information that would change the initial determination and why that information is necessary;
- d. a description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- e. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond the Control of Companion Life:

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of Companion Life, results in facilities, personnel or financial resources of Companion Life being unable to process claims for Covered Services, Companion Life will have no liability or obligation for any delay in the payment of claims for Covered Services, except that Companion Life will make a good faith effort to make payment for such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of Companion Life if Companion Life cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section XIV - Subrogation

In the event payment is made under this Policy to or on behalf of a Covered Plan Participant for any claim in connection with or arising from a Condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, the Employer and/or this Policy, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery such Covered Plan Participant has against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. Companion Life on behalf of the Employer and/or this Policy, and the Employer, shall have the right to subrogate out of any recovery or settlement the Participant is able to obtain including, but not limited to uninsured motorists, even if the Covered Plan Participant is not made whole for his/her losses. Companion Life may recover, on behalf of the Employer and/or this Policy, the amount of any payments made on the Covered Plan Participant's behalf minus Companion Life or the Employer's pro rata share for any costs and attorney fees incurred by the Covered Plan Participant in pursuing and recovering damages. Companion Life may subrogate, on behalf of the Employer and/or this Policy, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although the Employer may, but is not required to, take into consideration any special factors relating to the Covered Plan Participant's specific case in resolving the subrogation claim, the Employer will have the first of recovery or settlement amount the Covered Plan Participant is able to obtain even if the Covered Plan Participant or Covered Plan Participant's attorney believes that the Covered Plan Participant has not been made whole for his/her losses or damages by the amount of the recovery or settlement.

The Covered Plan Participant shall promptly execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigations as may be requested by Companion Life, and shall do whatever is necessary to enable Companion Life to exercise the Employer's subrogation rights and shall do nothing to prejudice such rights. Additionally, the Covered Plan Participant or the Covered Plan Participant's legal representative shall promptly notify Companion Life in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to Companion Life any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgment proceeds without the Employer's prior written consent. No waiver, release of liability, or other documents executed by a Covered Plan Participant without such notice to Companion Life shall be binding upon the Employer.

If the director or his designee, upon being petitioned by the Covered Plan Participant, determines that the exercise of subrogation by an insurer is inequitable and commits an injustice to the insured, subrogation is not allowed. Attorneys' fees and costs must be paid by the insurer from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law in accordance with Section 38-3-210.

Section XV – The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When a Covered Plan Participant becomes covered under Medicare and continues to be eligible and covered under the terms of this Group Health Plan Description, coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, coverage hereunder shall be secondary to any Medicare benefits. To the extent this Policy is primary, claims for Covered Services should be filed with Companion Life first.

Under Medicare, the Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such Covered Plan Participant. Also, the Employer may not induce such Covered Plan Participant to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

A Covered Plan Participant who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease (“ESRD”) must notify his/her Employer.

Individuals With End Stage Renal Disease

For a Covered Plan Participant who is entitled to Medicare coverage because of ESRD, group health coverage will be provided on a primary basis for 30 months beginning with the earlier of:

1. the month in which the individual became entitled to Medicare Part A ESRD benefits; or
2. the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retires and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health coverage will remain primary for the ESRD coordination period. For individual eligible for Medicare due to ESRD, group health coverage will be provided, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

This Policy will provide primary coverage to Covered Plan Participants if:

1. the Employer is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. the Covered Plan Participants are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage under the Policy is subject to the following terms:

1. For an enrolled individual, group health insurance coverage will be provided, as set forth herein, on a primary basis during any month in which that individual meets the description set out in the above paragraphs.

Section XV – The Effect of Medicare Coverage/Medicare Secondary Payer Provisions (Continued)

2. Individual entitlement to primary coverage under this sub-section will terminate automatically when:
 - a. the individual turns 65 years of age; or
 - b. the individual no longer qualifies for Medicare coverage because of disability; or
 - c. the individual elects Medicare as the primary payer. Coverage will terminate as of the date of such election.

3. Entitlement of the Covered Employee and/or his or her Covered Dependents to primary coverage under this sub-section will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. The Employer shall notify Companion Life, without delay, of any such change in status.

Miscellaneous

This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Policy.

Companion Life shall not be liable to the Employer or to any individual covered under this Policy on account of any nonpayment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this section.

Section XVI - Coordination of Benefits

Applicability

1. This Coordination of Benefit ("COB") provision applies to This plan when an Insured or the Insured's covered Dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in the Section entitled "Effect on the Benefits of This Plan."

Definitions

1. A. "PLAN" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Group insurance coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
 - b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

3. "THIS PLAN" is the part of the Policy that provides benefits for medical care expenses.
4. "PRIMARY PLAN"/"SECONDARY PLAN." The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.
5. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

6. "ALLOWABLE EXPENSE" means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made

Section XVI - Coordination of Benefits (Continued)

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

NOTE: When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

7. "CLAIM DETERMINATION PERIOD" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1. GENERAL - When there is a basis for a claim under This Plan and another plan, This Plan is a secondary plan which has its benefits determined after those of the other plan, unless:
 - a. the other plan has rules coordinating its benefits with those of This Plan; and
 - b. both those rules and This Plan's rules, in paragraph 2 below, require that This Plan's benefits be determined before those of the other plan.
2. RULES - This Plan determines its order of benefits using the first of the following rules which applies:
 - a. Non-Dependent/Dependent - The benefits of the Plan which covers the person as an Insured or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
 - b. Dependent Child/Parents Not Separated or Divorced - Except as stated in subparagraph 3. a. below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents":
 - 1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in 2) immediately above, instead it has a rule based upon the gender of the parents, and if, as a result, the plans do not agree on the order of benefits, then the rule in the other plan will decide the order of benefits.

- c. Dependent Child/Separated or Divorced Parents - Two or more plans may cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1) first, the plan of the parent with custody of the child;
 - 2) then, the plan of the spouse of the parent with the custody of the child; and
 - 3) finally, the plan of the parent not having custody of the child.

Section XVI - Coordination of Benefits (Continued)

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2. b. above.
- e. Active/Inactive Employee - The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - a. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Effect on the Benefits of This Plan

1. When This Section Applies. This Section applies when, in accordance with the "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in 2. immediately below.
2. REDUCTION IN THIS PLAN'S BENEFITS - The benefits of This Plan will be reduced when the sum of:
 - a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - b. the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Section XVI - Coordination of Benefits (Continued)

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give Us any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by Us is more than the amount We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.



COMPANION LIFE INSURANCE COMPANY
 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223-5666
 P.O. Box 100102, Columbia, South Carolina 29202-3102
 (803) 735-1251

APPLICATION FOR HIGH DEDUCTIBLE HEALTH PLAN

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant.) _____ (Product Name).

Name of Applicant: _____
 (Company Correct Legal Name)

Address of Applicant: _____
 (Physical)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the _____ day of _____, _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Application and Companion Life Insurance Company.

Health Savings Account: Do you currently have a Health Savings Account Administrator? Yes No

Is it a requirement that eligible employees participate in the HSA through your HSA Administrator? Yes N

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week at least 48 weeks a year for the Applicant. To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor other than substance abuse or chemical dependency; and 2) be performing the normal duties of his or her occupation at one of the Employer's normal places of business or at a location to which the Employee must travel to do his or her job. An Employee must begin work before he or she is considered Actively-at-work. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month that the requirement is met.

Periods of Continuous Employment as Prerequisite to Eligibility: Coverage for new Employees hired following the Effective Date of the Contract will begin on the first monthly Effective Date following _____ days of employment.

PARTICIPATION Requirements:

1. When the Employer pays 100% of the single coverage premium, all eligible Employees must enroll with at least single coverage.
2. When the Employer pays less than 100% of the single coverage premium:

Employee may elect not to receive coverage:
 The number of Employees not electing coverage is determined by group size.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period for the enrollment, Whichever is earlier.

- Late Enrollee:** An eligible Employee or Dependent who enrolls under this Contract other than during:
1. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
 2. A Special Enrollment period.

Late Enrollees will be excluded from coverage for 12 months then have a 6-month Pre-existing Condition Limitation.

Special Enrollment: If the Enrollment is eligible and not already enrolled, or if a Dependent is eligible and not already enrolled, Companion Life will allow the Employee or Dependent to enroll if each of the following is met:

1. The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
2. The Employee stated in writing at the time that coverage under a Group Health Plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
3. The Employee's or Dependent's coverage described in paragraph 1 above:
 - a. Was under a COBRA or state continuation provision and the coverage under the provision was exhausted; or
 - b. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment;
 - c. Was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
4. The Employee requests the enrollment not later than 31 days after the date prior coverage ended due to loss of eligibility or Employer contribution stopped as described above.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage. However, the Employee and Employee's spouse may be subject to the Pre-existing Condition Limitation period up to 12 months. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than a newborn, adopted child or child placed for adoption may be subject to the Pre-existing Condition Limitation period up to 12 months.

PRE-EXISTING CONDITION LIMITATIONS

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Enrollment Date.

The Pre-existing Condition Exclusion lasts until the earlier of:

- a. The member has not received medical care, treatment, or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends sometime after the Effective Date of coverage; or
- b. 12 months after the Enrollment Date.

In the case of a Late Enrollee, the Pre-existing Condition Exclusion begins on the Enrollment Date and lasts for 18 months.

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or eligible dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

Companion Life shall count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

The Pre-existing Condition Limitations do not apply to Routine Maternity Care or to Generic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with the Employee or Employee's spouse for the purpose of adoption before he or she reaches 18 years of age if the Employee applied for coverage and the premium was paid within 31 days from the birth, adoption or placement for adoption. If, however, the Employee or Dependent does not have Creditable Coverage after the end of the first 63-day period, the above newborn and adopted provisions do not apply.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitation apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Creditable Coverage: Benefits or coverage provided under:

1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Services or a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulation;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. Excepted Benefits is defined in the Contract.

Companion Life will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

The period of any Pre-existing Condition exclusion is reduced or eliminated by the total periods of Creditable Coverage listed above.

It is understood and agreed that the Applicant shall pay Companion Life, in advance, the premium specified in the Master Contract on behalf of the Applicant's Employee's who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Companion Life and the Applicant. Coverage is not effective unless and until approved by the Underwriting Department at Companion Life's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from the policyholder's funds or funds contributed by the insured person, or from both.

The Applicant hereby expressly acknowledges that it understands that this application constitutes a Contract solely between the Applicant and Companion Life.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Companion Life and that no person, entity or organization other than Companion Life shall be held accountable or liable to the Applicant for any of Companion Life's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Companion Life other than those obligations created under other provisions of this Contract.

Dated at (City) _____, [South Carolina], this _____, day of _____, _____

Name of Application (Company Name)

By: _____ (Authorized Signature) _____ (Signature of Agent/Broker)

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.