

SERFF Tracking Number: FLHI-126789389 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
 Project Name/Number: /

Filing at a Glance

Company: Coventry Health and Life Insurance Co.

Product Name: AR Schedule of Benefits, SERFF Tr Num: FLHI-126789389 State: Arkansas

Domestic Partnership Rider and Certificate of Coverage PPACA

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 46993
 Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Nora Ambros, Tony Jones Disposition Date: 10/25/2010

Date Submitted: 10/06/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

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: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 10/25/2010

Explanation for Other Group Market Type:

State Status Changed: 10/25/2010

Deemer Date:

Created By: Tony Jones

Submitted By: Tony Jones

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

Filing Description:

We are filing a Certificate of Coverage, Schedule of Benefits and Domestic Partnership Rider. We updated the Certificate of Coverage and Schedule of Benefits to be PPACA compliant. The revised documents will be used and filed in Tennessee, Mississippi and Arkansas. Please see Statement of Variability under the Supporting Documentation tab.

The forms do not require a rate filing. Changes fall within the benefit relativity ranges.

SERFF Tracking Number: FLHI-126789389 State: Arkansas
Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
Project Name/Number: /

Please let me know if you have any questions.

Respectfully,

Tony Jones
800-445-1425 x 7610

Company and Contact

Filing Contact Information

Tony Jones, Regulatory Compliance Analyst tdjones1@cvty.com
3200 Highland Avenue 630-737-7610 [Phone]
7th Floor 630-737-4220 [FAX]
Downers Grove, IL 60515

Filing Company Information

Coventry Health and Life Insurance Co. CoCode: 81973 State of Domicile: Delaware
6705 Rockledge Drive Group Code: 1137 Company Type:
Suite 900 Group Name: State ID Number:
Bethesda, MD 20817 FEIN Number: 75-1296086
(800) 843-7421 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? Yes
Fee Explanation: 3 forms x \$50 = \$150
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Co.	\$150.00	10/06/2010	40329093

SERFF Tracking Number: FLHI-126789389 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
 Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/25/2010	10/25/2010

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	10/12/2010	10/12/2010	Tony Jones	10/18/2010	10/18/2010

SERFF Tracking Number: *FLHI-126789389* *State:* *Arkansas*
Filing Company: *Coventry Health and Life Insurance Co.* *State Tracking Number:* *46993*
Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA*
Project Name/Number: /

Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FLHI-126789389* State: *Arkansas*
 Filing Company: *Coventry Health and Life Insurance Co.* State Tracking Number: *46993*
 Company Tracking Number:
 TOI: *H16G Group Health - Major Medical* Sub-TOI: *H16G.001A Any Size Group - PPO*
 Product Name: *AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA*
 Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Supplemental Rider for Domestic Partner Benefits	Approved-Closed	Yes

SERFF Tracking Number: FLHI-126789389 State: Arkansas
Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/12/2010

Submitted Date 10/12/2010

Respond By Date

Dear Tony Jones,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage, TN AR MS Group PPO_COC_10_CHL (9/2010) (Form)
- Schedule of Benefits, TNARMS SOB10_CHL (9/2010) (Form)

Comment:

It is requested that you provide written certification that all benefits payable a PPO (In-Network) and a non-PPO(Out of Network) will comply with our Bulletin 9-85 which states in part that there should be no more than a 25% differential in payment between a PPO and Non-PPO.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: FLHI-126789389 State: Arkansas
Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/18/2010
Submitted Date 10/18/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter of October 12, 2010.

Response 1

Comments: This is to certify that the coinsurance benefit levels between a PPO and a Non-PPO will not be more than a 25% differential.

Related Objection 1

Applies To:

- Certificate of Coverage, TN AR MS Group PPO_COC_10_CHL (9/2010) (Form)
- Schedule of Benefits, TNARMS SOB10_CHL (9/2010) (Form)

Comment:

It is requested that you provide written certification that all benefits payable a PPO (In-Network) and a non-PPO(Out of Network) will comply with our Bulletin 9-85 which states in part that there should be no more than a 25% differential in payment between a PPO and Non-PPO.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for reviewing our filing. Please let me know if you have any questions.

Regards,
Tony Jones

SERFF Tracking Number: *FLHI-126789389* *State:* *Arkansas*
Filing Company: *Coventry Health and Life Insurance Co.* *State Tracking Number:* *46993*
Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA*
Project Name/Number: /

Sincerely,
Nora Ambros, Tony Jones

SERFF Tracking Number: FLHI-126789389 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/25/2010	TN AR MS Group PPO_COC _10_CHL (9/2010)	Certificate	Certificate of Coverage	Initial		40.300	Certificate of Coverage 10052010.pdf
Approved-Closed 10/25/2010	TNARMS SOB10_CHL L (9/2010)	Schedule Pages	Schedule of Benefits	Initial			TNARMS_SO B10_CHL 10052010.pdf
Approved-Closed 10/25/2010	TN AR MS- DOMPART -08/2010	Policy/Cont ract/Fratern al	Supplemental Rider for Domestic Partner Benefits	Initial		41.400	Domestic Partner Rider.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					

Employee Benefits

2010

PREFERRED PROVIDER ORGANIZATION ("PPO")

CERTIFICATE OF COVERAGE

NOTICE

THIS CERTIFICATE AND ALL ATTACHED RIDERS SHOULD BE READ AND RE-READ IN THEIR ENTIRETY

Benefits underwritten and administered by Coventry Health and Life Insurance Company

THIS HEALTH PLAN HAS AN OUT-OF-NETWORK OPTION WHICH GIVES YOU THE OPPORTUNITY TO SEEK CARE FROM NON-PARTICIPATING PROVIDERS. UTILIZING THE OUT-OF-NETWORK OPTION WILL INCREASE THE AMOUNT YOU PAY FOR THE CARE YOU RECEIVE. PLEASE READ THE PROVISION ENTITLED "COPAYMENTS, COINSURANCE, AND DEDUCTIBLES" WHICH APPEARS AS SECTION 2.6 BELOW AND CALL OUR MEMBER SERVICES DEPARTMENT WITH QUESTIONS.

Please consult Your Member materials and Provider Directory for more details. If you have any additional questions, please write or call us at:

**Coventry Health and Life Insurance Company
Attn: Member Service
5350 Poplar Ave, Suite 390
Memphis, Tennessee 38119
(866) 513-0413**

Table of Contents

Table of Contents..... 2

SECTION 1 12

1.1 “Abortion” 12

1.2 “Acute” 12

1.3 “Administrative Appeal” 12

1.4 “Adverse Benefit Determination” 12

1.5 “Agreement” 12

1.6 “Alcoholism” 13

1.7 “Alternate Facility” 13

1.8 “Alternate Recipient” 13

1.9 “Amendment” 13

1.10 “Ancillary Service” 13

1.11 “Appeal” 13

1.12 “Authorization/Prior Authorization” 13

1.13 “Authorized Representative” 14

1.14 “Basic Health Services” 14

1.15 “Certificate of Creditable Coverage” 14

1.16 “Chemical Dependency” 14

1.17 “Chiropractic Services” 14

1.18 “Chronic Medical Condition” 14

1.19 “COBRA” 14

1.20 “Coinsurance” 15

1.21 “Complaint” 15

1.22 “Confinement” and “Confined” 15

1.23 “Contract Year” 15

1.24 “Copayment” 15

1.25 “Cosmetic Services and Surgery” 15

1.26 “Coverage” or “Covered” 15

1.27 “Covered Services” 16

1.28 “Creditable Coverage” 16

1.29	“Custodial Care”	17
1.30	“Deductible”	17
1.31	“Dependent”	17
1.32	“Designated Transplant Network Facility”	17
1.33	“Designated Transplant Network Physician”	17
1.34	“Detoxification”	17
1.35	“Directory of Health Care Providers” (“Provider Directory”)	17
1.36	“Durable Medical Equipment”	18
1.37	“Effective Date”	18
1.38	“Eligible Employee”	18
1.39	“Eligible Expenses”	18
1.40	“Emergency” and “Medical Emergency”	18
1.41	“Enrolling Unit”	19
1.42	“Enrollment/Change Form”	19
1.43	“ERISA”	19
1.44	“Experimental or Investigational”	19
1.45	“Full-time Student”	20
1.46	“Genomics”	20
1.47	“Grievance”	20
1.48	“Group”	20
1.49	“Group Enrollment Agreement”	20
1.50	“Group Effective Date”	20
1.51	“Health Services”	21
1.52	“Home Health Agency”	21
1.53	“Home Health Care Services”	21
1.54	“Hospital”	21
1.55	“Infertility”	21
1.56	“Infertility Services”	21
1.57	“Injectables”	21
1.58	“Injury”	22
1.59	“Inquiry”	22
1.60	“Intensive Care Unit (ICU)”	22

1.61	“Investigational Review Board (IRB)”	22
1.62	“Late Enrollees”	22
1.63	“Lifetime”	22
1.64	“Maintenance Therapy”	22
1.65	“Maternity Services”	22
1.66	“Medical Director”	22
1.67	“Medically Necessary”	22
1.68	“Medical Necessity Appeal”	23
1.69	“Medicare”	23
1.70	“Member”	23
1.71	“Member Advisory Committee”	23
1.72	“Member Effective Date”	24
1.73	“Mental Health and Substance Abuse Designee”	24
1.74	“Mental Health Condition(s)”	24
1.75	“Nanometrics”	24
1.76	“Non-Participating Provider”	24
1.77	“Officer”	24
1.78	“Open Enrollment Period”	24
1.79	“Orthotic Appliances and Prosthetic Devices”	24
1.80	“Out-of-Network Rate”	24
1.81	“Partial Hospitalization”	25
1.82	“Participating Provider”	25
1.83	“Peer-Reviewed Medical Literature”	25
1.84	“Physician”	25
1.85	“Plan”	25
1.86	“Post-Service Appeal”	25
1.87	“Pre-Existing Medical Conditions”	26
1.88	“Pre-Service Appeal”	26
1.89	“Premium”	26
1.90	“Preventive Care Services”	26
1.91	“Provider/Provider Network”	26
1.92	“Qualified High Deductible Health Plan (QHDHP)”	27

1.93	“Qualified Medical Child Support Order” (“QMCSO”)	27
1.94	“Reconstructive Surgery”	27
1.95	“Retiree”	27
1.96	“Rider”	27
1.97	“Schedule of Covered Services”	28
1.98	“Semi-private Accommodations”	28
1.99	“Service Area”	28
1.100	“Skilled Nursing Facility (SNF)”	28
1.101	“Special Enrollment Period”	28
1.102	“Specialty Care Physician/Specialist”	28
1.103	“Subscriber”	28
1.104	“Total Disability”	28
1.105	“Urgent Care Appeal”	29
1.106	“Urgent Care Services”	29
1.107	“You or Your”	30
<i>SECTION 2 USING YOUR BENEFITS</i>		31
2.1	Membership Identification (ID) Card	31
2.2	Health Services Rendered by Providers	31
2.3	Prior Authorization	33
2.4	Second Opinion Policy	34
2.5	Authorization	34
2.6	Copayments, Coinsurance, and Deductibles	34
2.7	Out-of-Network Rates	35
2.8	Out-of-Pocket Maximum	36
2.9	Maximum Lifetime Benefit	36
2.10	Qualified High Deductible Health Plans	36
2.11	Participating Provider Terminations	37
2.12	How to Contact the Plan	37
2.13	Provider Hold Harmless	38
2.14	Plan Has Authority to Grant Coverage	38
2.15	Coverage for Services by Non-Participating Providers	38
<i>SECTION 3 ENROLLMENT AND ELIGIBILITY</i>		40

3.1	Eligibility	40
3.2	Change of Group's Eligibility Rules.....	41
3.3	Persons Not Eligible to Enroll	41
3.4	Enrollment.....	41
3.5	Special Enrollment.....	42
SECTION 4 EFFECTIVE DATES.....		45
4.1	Effective Date	45
4.2	Member Effective Date for Dependents	45
SECTION 5 TERMINATION OF COVERAGE		47
5.1	Conditions for Termination of a Member's Coverage Under the Agreement.	47
5.2	Termination of Coverage For Members	49
5.3	Effect of Termination.....	50
5.4	Discontinuation of Coverage	50
5.5	Certificates of Creditable Coverage.....	50
SECTION 6 COVERED SERVICES.....		51
SECTION 7 OUT OF THE SERVICE AREA		86
7.1	Confinement in non-Participating Hospital or Hospital Out of Service Area	86
7.2	Basic Health Services Rendered Out of Service Area.....	86
7.3	Emergency for Out of Service Area.....	86
SECTION 8 EXCLUSIONS AND LIMITATIONS.....		88
8.1	Certification of Creditable Coverage	99
SECTION 9.....		102
CLAIMS AND REIMBURSEMENT		102
9.1	Participating Provider Expenses	102
9.2	Notice of Claim.....	102
9.3	Time of Payment of Claims - applies only to Plans delivered in and governed by the laws of the State of Mississippi:	103
9.4	Section Timing.....	103
9.5	Reinstatement.....	104
9.6	Payment to Public Entities	104
SECTION 10 COORDINATION OF BENEFITS.....		105

10.1	Coordination With Other Plans (other than Medicare).....	105
10.2	COB Definitions	105
10.3	Order of Benefit Determination Rules.....	107
10.4	Effect On The Benefits of the Plan	109
10.5	Coordination of Benefits with Medicare.....	110
10.6	Right to Receive and Release Needed Information	111
10.7	Facility of Payment.....	111
10.8	Right of Recovery	111
<i>SECTION 11 CONTINUATION, CONVERSION, EXTENSIONS OF COVERAGE</i>		<i>112</i>
11.1	Continuation Coverage Under COBRA (Consolidated Omnibus Budget Reconciliation Act).....	112
11.2	Qualifying Events for Continuation Coverage Under Federal Law	112
11.3	Notification of Requirements and Election Period for Continuation Coverage Under Federal Law	113
11.4	Terminating Events for Continuation Coverage Under Federal Law.....	113
11.5	Qualifying Events for Continuation Coverage Under State Law	114
11.6	Conversion [- not available for Plans delivered in and governed by the laws of the State of Mississippi].....	114
11.7	Extension of Coverage if a Member is Confined.....	115
11.8	Extension of Coverage Upon Total Disability.....	116
<i>SECTION 12</i>		<i>117</i>
<i>RESOLVING COMPLAINTS AND GRIEVANCES</i>		<i>117</i>
12.1	Complaints and Inquiries	117
12.2	Appeals	117
<i>SECTION 13 CONFIDENTIALITY OF YOUR HEALTH INFORMATION</i>		<i>125</i>
13.1	Privacy Information	125
13.2	Notice of Privacy Practices.....	125
<i>SECTION 14 GENERAL PROVISIONS</i>		<i>127</i>
14.1	Applicability	127
14.2	Governing Law	127

14.3	Limitation of Action	127
14.4	Nontransferable.....	127
14.5	Relationship Among Parties Affected by Agreement.....	127
14.6	Contractual Relationships	127
14.7	Plan is Not Employer	128
14.8	Reservations and Alternatives.....	128
14.9	Severability	128
14.10	Valid Amendment.....	128
14.11	Waiver.....	129
14.12	Entire Agreement	129
14.13	Participation in Policies of The Plan.....	129
14.14	Records	129
14.15	ERISA.....	130
14.16	Examination of Members.....	130
14.17	Clerical Error	130
14.18	Notice.....	130
14.19	Workers' Compensation.....	130
14.20	Conformity with Statutes	130
14.21	Non-Discrimination	131
14.22	Provisions Relating to Medicaid Eligibility.....	131
14.23	Policies and Procedures	131
14.24	Discretionary Authority	131
14.25	Value Added Services.....	131

SECTION 15 UTILIZATION REVIEW POLICY AND PROCEDURES..... 132

15.1 Utilization Review Circumstances..... 132

15.2 Timing Of Utilization Review Decisions 132

15.3 Reconsideration..... 133

15.4 Right To Appeal..... 133

Coventry Health and Life Insurance Company (CHL)

Certificate of Coverage

The Agreement between Coventry Health and Life Insurance Company (hereafter called "the Plan") and You and between the Plan and Your Dependents as Members of the Plan is made up of:

- This Certificate of Coverage (COC) and Amendments;
- The Enrollment/Change Form;
- Applicable Riders;
- The Group Enrollment Agreement;
- Member Handbook & Provider Directory; and
- Schedule of Benefits.

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

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY.

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

You may examine the Agreement at the office of the Enrolling Unit during regular business hours. This COC, the Group Enrollment Agreement, the Group Application for Benefit Offerings, any individual Subscriber Enrollment/Change Forms, Amendments, Schedules and Riders are collectively referred to as the Agreement.

From time to time, any of the above documents may be amended. When that occurs, the Plan may provide a revision to You for this Agreement. You should keep this document in a safe place for Your future reference.

The Plan is responsible for making benefit determinations in accordance with the Group Enrollment Agreement, this COC and the Plan's agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim or Authorization for payment of a recommended service, the treating Provider may request reconsideration of that decision through the Plan's Provider dispute resolution procedure. Regardless of whether the Provider requests reconsideration of the decision through the dispute

resolution procedure, You may request reconsideration of that decision through the Member Complaint and Grievance Procedure described in Section 12 of this COC. The Plan's Provider dispute resolution procedure and the Member Complaint and Grievance Procedure are separate and independent of each other.

SECTION 1
DEFINITIONS

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

1.1 "Abortion"

The termination of pregnancy.

- **Medically Necessary Abortion**

The termination of pregnancy when the pregnancy jeopardizes the mothers' life or if the fetus is diagnosed to have congenital anomalies incompatible with life.

- **Elective Abortion**

The voluntary termination of pregnancy for other than medical reasons as described in Medically Necessary Abortion.

1.2 "Acute"

Refers to an Illness or Injury that is both severe and of recent onset.

1.3 "Administrative Appeal"

An Appeal of a decision that has not been issued for Medical Necessity or medical appropriateness, and is administrative in nature. Examples of Administrative Appeal include, but are not limited to Deductibles, Copayments, or a specifically excluded benefit, such as acupuncture.

1.4 "Adverse Benefit Determination"

A denial, reduction, or termination of, or failure to pay (in whole or part) for a benefit, including any such denial reduction, termination, or failure to pay for a benefit that is based on a determination of a Member's plan eligibility, application of utilization review, a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required premiums or contributions toward cost of coverage and failure to cover a benefit because it is Experimental or Investigational or not Medically Necessary or appropriate.

1.5 "Agreement"

Refers to this COC, the Group Enrollment Agreement of the Enrolling Unit, the Group Application for Benefit Offerings, any individual Subscriber Enrollment/Change Forms, Amendments, Schedules, and Riders, and other documents which constitute the agreement regarding the benefits, exclusions and other conditions between the Plan and the Enrolling Unit.

1.6 “Alcoholism”

The chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

1.7 “Alternate Facility”

A non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency Health Services;
- Urgent Care Services, or prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Health Services or Substance Abuse Services.

1.8 “Alternate Recipient”

The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.

1.9 “Amendment”

Any attached written description of additional or alternative provisions to the Agreement and/or this COC. Amendments are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.

1.10 “Ancillary Service”

Those services not performed by an MD or DO and usually associated with, but not limited to lab, x-ray, nursing, dietary, pharmacy, and rehabilitative services.

1.11 “Appeal”

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a Health Service request or benefit that You believe You are entitled to receive.

1.12 “Authorization/Prior Authorization”

Approval for payment for certain services to be performed as given by the Plan. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

Emergency Health Services performed in an emergency room of a hospital do not require Prior Authorization.

1.13 “Authorized Representative”

An Authorized Representative is an individual authorized by You or state law to act on Your behalf in obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent in emergent situations. For Appeals, Your Authorized Representative must have an Authorization for Disclosure of Personal Health Information to Appeals Representative form signed by You. Call the Member Services Department to obtain this form or visit the website listed on Your Schedule of Important Numbers and Addresses to obtain this form.

1.14 “Basic Health Services”

Health Services which a Member may reasonably require in order to be maintained in good health, including as a minimum, inpatient Hospital, Physician, outpatient services, and Emergency Health Services that are covered under this COC. Benefits provided by Riders attached to this COC are not considered Basic Health Services for the purpose of this definition.

1.15 “Certificate of Creditable Coverage”

Written certification of the timeframe of Creditable Coverage.

1.16 “Chemical Dependency”

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

1.17 “Chiropractic Services”

Services that are Medically Necessary, clinically appropriate and rendered by a chiropractor working within the chiropractor’s lawful scope of practice.

1.18 “Chronic Medical Condition”

A health condition that is continuous or persistent over an extended period of time (greater than 6 months) that;

- Requires periodic visits with a health care provider, and
- May be associated with episodic rather than continuous periods of incapacity.

1.19 “COBRA”

The Consolidated Omnibus Budget Reconciliation Act.

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 14 of 134]

1.20 “Coinsurance”

The percentage amount You must pay in relation to a specified benefit and is payable as a condition of the receipt of certain services as provided in this COC. The out of network Coinsurance is a standard percentage, as referenced in Your Schedule of Benefits, plus the difference between the Plan’s Out of Network Rate and the Provider’s billed amount.

1.21 “Complaint”

Any expression of dissatisfaction expressed by You or Your Authorized Representative regarding a Health Plan issue. A verbal Complaint is informational in nature and cannot be Appealed (e.g., a Complaint concerning long wait times at a Physician’s office). A written Complaint is considered to be a Grievance.

1.22 “Confinement” and “Confined”

An uninterrupted stay of at least twenty-four (24) hours following formal admission to a Hospital, an Alternate Facility or SNF.

1.23 “Contract Year”

The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary.

1.24 “Copayment”

A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this COC. There may be more than one Copayment charged by the same Provider on the same day.

1.25 “Cosmetic Services and Surgery”

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

1.26 “Coverage” or “Covered”

The COC provides for two benefit levels: an In-Network benefit level for Health Services obtained through Participating Providers and an Out-of-Network level for Health Services rendered by Providers outside the Plan’s network. You have the flexibility of deciding which Coverage level You wish to access at the time You obtain medical care. If You follow the requirements outlined in Section 6 and stay within the Plan’s network of Participating Providers, services will be Covered at the In-Network benefit level. Services from Non-Participating Providers will be Covered at the lower Out-of-Network benefit level. The In-

Network and Out-of-Network benefits are described in the Schedule of Benefits attached to this COC. The entitlement by a Member to Covered Services under the COC, subject to the terms, conditions, limitations and exclusions of the COC, including the following conditions: (a) Health Services which must be provided when the COC is in effect; and (b) Health Services which must be provided prior to the date that any of the termination conditions listed under Section 5 of this COC occur; and (c) Health Services which must be provided only when the recipient is a Member and meets all eligibility requirements specified in the COC; and (d) Health Services which are Medically Necessary.

1.27 “Covered Services”

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

1.28 “Creditable Coverage”

Coverage of an individual through one or more of the following:

- group health plan;
- health maintenance organization (HMO);
- an individual health insurance policy;
- Medicare;
- Medicaid;
- Military Health;
- medical program of the Indian Health Service or of a Tribal Organization;
- State health pool;
- FEHP health plan;
- Public health plan; or
- Peace Corps Plan.

Prior Coverage under any of the above referenced plans may be credited toward a Member’s Pre-existing Condition waiting period under this Certificate provided there was not a lapse of coverage of more than sixty-three (63) consecutive days. If the lapse of Coverage is more than sixty-three (63) consecutive days, credit of Coverage is lost and a Pre-existing Condition waiting period may be applied.

1.29 “Custodial Care”

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

1.30 “Deductible”

The dollar amount of medical expenses for Covered Services that You are responsible for paying in a calendar/Contract Year before benefits subject to the Deductible are payable under this Agreement. If You consult an Out of Network Provider, the difference between the Plan Out of Network Rate and the Provider’s billed charges does not apply to the Deductible.

1.31 “Dependent”

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

1.32 “Designated Transplant Network Facility”

A Hospital, appointed as a Designated Transplant Network Facility by the Plan, that has contracted with the Coventry Transplant Network, or its successor, to render Medically Necessary and medically appropriate Health Services for Covered transplants. You may request a listing, that may be amended from time to time, of Designated Transplant Network Facilities from the Member Services Department listed in the Schedule of Important Numbers.

1.33 “Designated Transplant Network Physician”

A Physician, appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically Necessary and medically appropriate Health Services for Covered transplants.

1.34 “Detoxification”

Hospital inpatient medical care to ameliorate acute medical conditions associated with Chemical Dependency.

1.35 “Directory of Health Care Providers” (“Provider Directory”)

A listing of Participating Providers. Please be aware the information in the directory is subject to change. The list of Participating Providers is available on

the website or upon request. You will be provided with an updated directory at least once each calendar/Contract Year showing addition and deletions.

1.36 “Durable Medical Equipment”

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

1.37 “Effective Date”

The date of Coverage as determined by the Group and agreed to by the Plan, as set forth in the Group Enrollment Agreement.

1.38 “Eligible Employee”

An individual employed by the Enrolling Unit who meets the eligibility requirements specified in the Group Application for Benefit Offerings, Group Enrollment Agreement or other applicable Agreement document.

1.39 “Eligible Expenses”

Charges for Covered Health Services, incurred while the Agreement is in effect.

1.40 “Emergency” and “Medical Emergency”

A medical condition that manifests itself by symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member (or, in the case of a woman who is pregnant, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to the Member's bodily functions; or
- Serious dysfunction of any bodily organ or part.

Some examples of an Emergency medical condition include but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

Generally, Eligible Expenses for Emergency Health Services are the charges for the Health Services and items furnished in a Hospital which are required to determine, evaluate and/or treat during the course of the Emergency and when Medically Necessary for stabilization and initiation of treatment. The Emergency Health Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this COC. The Member will be assessed the same Copayment whether the Emergency Health Services are rendered by a Participating or Non-Participating Provider. (Refer to the Schedule of Benefits in the back of the COC). **EMERGENCY HEALTH SERVICES RECEIVED WHILE YOU ARE OUTSIDE OF THE SERVICE AREA ARE COVERED WHEN THE REQUIREMENTS EXPLAINED IN SECTION 7 OF THIS COC ARE FOLLOWED. IF MEDICALLY NECESSARY FOLLOW-UP CARE RELATED TO THE INITIAL MEDICAL EMERGENCY IS REQUIRED, YOU MUST OBTAIN PRIOR AUTHORIZATION TO BE ELIGIBLE FOR THE IN-NETWORK LEVEL OF BENEFITS.**

When an Emergency occurs, a Member should seek medical attention immediately from a Hospital, Physician's office or other Emergency facility. If the Member is unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would endanger the Member, the Member should receive medical attention from the Hospital to which he or she is taken, and must notify the Plan within forty-eight (48) hours of the onset of the Emergency, or within a reasonable period as dictated by the circumstances. At the request of the Plan, You must make available full details of the Emergency Health Services received.

1.41 "Enrolling Unit"

The employer, other defined, or other legally constituted group with whom the Agreement is made.

1.42 "Enrollment/Change Form"

Your application for enrollment in the Plan.

1.43 "ERISA"

The Employee Retirement Income Security Act of 1974, as amended.

1.44 "Experimental or Investigational"

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA;
- Any health product or service that is subject to Investigational Review Board

(IRB) review or approval;

- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

1.45 “Full-time Student”

An eligible Dependent as defined in the Group Application for Benefit Offerings and Schedule of Benefits who is enrolled in and attending, full-time, a recognized course of study or training at:

- (a) An accredited high school or vocational school; or
- (b) An accredited college or university; or
- (c) A licensed technical school, beautician school, automotive school, or similar training school.

1.46 “Genomics”

Genomic based therapeutics are drugs that are the products of gene technology and the molecular basis of disease associated with biological targets (e.g. monoclonal antibodies).

1.47 “Grievance”

A written Complaint submitted by or on behalf of an enrollee regarding the:

- (a) Availability, delivery or quality of health care services, including a Complaint regarding an adverse determination made pursuant to utilization review; or
- (b) Claims payment, handling or reimbursement for health care services; or
- (c) Matters pertaining to the contractual relationship between an enrollee and a health carrier.

Depending on the nature of Your Grievance, the Plan will handle Your Grievance as a Complaint, Pre-Service Appeal, Post-Service Appeal, or Urgent Care Appeal. See Section 12, Resolving Complaints and Grievances, for additional information.

1.48 “Group”

The organization or firm contracting with the Plan to arrange Health Services for Subscribers and their Dependents through which eligible Subscribers and Dependents become entitled to the Covered Services described herein.

1.49 “Group Enrollment Agreement”

The agreement between the Group and the Plan that states the agreed upon contractual rights and obligations of and afforded to the Plan, the Group, and Members, and that describes the premiums.

1.50 “Group Effective Date”

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 20 of 134]

The date that is specified in the Group Enrollment Agreement as the Effective Date of this Agreement.

1.51 "Health Services"

The health care services and supplies Covered under the Agreement, except to the extent that such health care services and supplies are limited or excluded under the Agreement.

1.52 "Home Health Agency"

A program which is engaged in providing Home Health Services, is properly licensed or otherwise qualified and authorized pursuant to the law of the jurisdiction in which treatment is received, and is Medicare certified.

1.53 "Home Health Care Services"

Those services, determined by the Plan to be Medically Necessary, which would be Covered if provided in an acute care or SNF setting. They must be part of a treatment plan, ordered by the Member's Physician and Authorized by the Plan. They must be provided by appropriately licensed Providers. The services include, but are not limited to, physical therapy, speech therapy and occupational therapy and other skilled nursing services.

1.54 "Hospital"

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

1.55 "Infertility"

Infertility means the inability of a woman to conceive a pregnancy after twelve (12) months of unprotected sexual intercourse between a male and a female, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).

1.56 "Infertility Services"

Those Health Services designed for the primary purpose of successfully fostering and achieving conception and pregnancy.

1.57 "Injectables"

Prescription medications injected by or under the direct supervision of a

physician. Self-injectables are medications that are injected by the patient.

1.58 "Injury"

Bodily damage other than Illness including all related conditions and recurrent symptoms.

1.59 "Inquiry"

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint. An example of an Inquiry would be benefit questions, claims status, or a change of personal demographic information.

1.60 "Intensive Care Unit (ICU)"

That part of a Hospital specifically designed as an Intensive Care Unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards. Care includes close observation by trained and qualified personnel whose duties are primarily confined to the ICU.

1.61 "Investigational Review Board (IRB)"

A university or Participating Hospital panel composed of faculty and researchers that determines whether a procedure will be rejected as experimental and investigational or approved as medically appropriate.

1.62 "Late Enrollees"

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

1.63 "Lifetime"

Lifetime refers to the natural life of the member.

1.64 "Maintenance Therapy"

Rehabilitative services and associated expenses designed primarily to be long-term, with no significant medical improvement to the patient being reasonably expected as determined by the Your Physician or Medical Director.

1.65 "Maternity Services"

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

1.66 "Medical Director"

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

1.67 "Medically Necessary"

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 22 of 134]

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

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

1.68 "Medical Necessity Appeal"

An Appeal of a determination by the Plan or its designed utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

1.69 "Medicare"

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

1.70 "Member"

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

1.71 "Member Advisory Committee"

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 23 of 134]

The Committee which the Plan has organized to permit Members to make suggestions about the policies and operations of the Plan.

1.72 “Member Effective Date”

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

1.73 “Mental Health and Substance Abuse Designee”

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse Services under contract to the Plan.

1.74 “Mental Health Condition(s)”

Any condition or disorder defined by categories listed in the most recent edition of the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders except for Chemical Dependency.

1.75 “Nanometrics”

Nanometric based therapeutics are products that use ultra-small (nanometric/molecular-sized) electronic or mechanical devices.

1.76 “Non-Participating Provider”

A Provider who has no direct or indirect written agreement with the Plan to provide Health Services to Members.

1.77 “Officer”

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

1.78 “Open Enrollment Period”

The period of time during which any Eligible Employee may enroll with the Plan for Coverage under this COC.

1.79 “Orthotic Appliances and Prosthetic Devices”

Orthotic Appliances correct a defect of a body form or function, whereas Prosthetic Devices aid body functioning or replace a limb or body part.

1.80 “Out-of-Network Rate”

Except for Emergency services;

The Out-of-Network Rate for claims processed by the Plan shall be the lesser of the Non-Participating Provider's billed charges or the current Medicare fee schedule as determined by the Plan for the services and supplies rendered. If there is no corresponding Medicare rate for the particular service, the Out-of-Network Rate will be determined by the Plan.

The Out-of-Network Rate for non-facility claims processed by the Plan's behavioral health vendor shall be the lesser of the Non-Participating Provider's

billed charges or the current Medicare fee schedule as determined by the Plan for the services and supplies rendered. If there is no corresponding Medicare rate for the particular service, the Out-of-Network Rate will be determined by the Plan.

The Out-of-Network Rate for facility claims processed by the Plan's behavioral health vendor shall be the lesser of the Non-Participating Provider's billed charges or the average amount the behavioral health vendor pays its Participating Providers for the same service(s).

For Emergency services, the Out-of-Network Rate for claims processed by the Plan shall be the Non-Participating Provider's billed charges. Contact the Plan regarding the Out-of-Network Rate in such cases.

You are responsible for charges that exceed the Plan's Out-of-Network Rate for Non-Participating Providers. This could result in You having to pay a significant portion of Your claims. Balances above the Out-of-Network Rate do NOT apply to Your [Deductible] [or] Out-of-Pocket Maximum. Please feel free to contact the Plan regarding the Out-of-Network Rate in such cases.

1.81 "Partial Hospitalization"

Physician directed intensive or intermediate treatment for less than twenty-four (24) hours, but more than four (4) hours in a day, in a licensed or certified facility or program.

1.82 "Participating Provider"

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

1.83 "Peer-Reviewed Medical Literature"

A scientific study which has been published in the English language (mostly American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

1.84 "Physician"

Any Doctor of Medicine, "M.D.", Doctor of Osteopathy, "D.O.", or chiropractor who is duly licensed and qualified under the law of the jurisdiction in which treatment is received. Includes duly certified nurse practitioners working within the scope of their practice and supervised by a duly licensed physician.

1.85 "Plan"

Coventry Health and Life Insurance Company.

1.86 "Post-Service Appeal"

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 25 of 134]

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

1.87 “Pre-Existing Medical Conditions”

A limitation or exclusion of benefits relating to any medical condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed Provider within the six (6) months immediately preceding the Member’s Enrollment Date under the Agreement and extending for a period of not more than twelve (12) months after the Enrollment Date (or in the case of a Late Enrollee eighteen (18) months) or as to pregnancy existing on the effective date of Coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

Dependent children under the age of 19 are not subject to any Pre-Existing Medical Conditions exclusions or limitations.

1.88 “Pre-Service Appeal”

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization.

1.89 “Premium”

The monthly fee required from each Enrolling Unit on behalf of each Subscriber and each Enrolled Dependent in accordance with the terms of the Agreement.

1.90 “Preventive Care Services”

Medical services (as defined by the United States Preventive Services Task Force - with rating of "A" or "B", Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and comprehensive guidelines supported by the Health Resources and Services Administration) provided to prevent or arrest the further manifestation of human illness or injury. These services include, but may not be limited to:

- Periodic health evaluations, including tests and diagnostic procedures in connection with routine examinations;
- Routine prenatal care;
- Well-child care; and
- Adult and child immunizations.

Preventive Care Services does not include any service or benefit intended to treat an existing illness, injury, or condition.

1.91 “Provider/Provider Network”

A Physician, Hospital, SNF, Home Health Agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received. Health care practitioners must be working within the scope of their license/practice.

1.92 “Qualified High Deductible Health Plan (QHDHP)”

A health plan with Deductible and out-of-pocket limits for individuals and families that meets requirements under section 223 of the Internal Revenue Code. The limits will be found in Your Schedule of Benefits (SOB).

1.93 “Qualified Medical Child Support Order” (“QMCSO”)

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

A “Medical Child Support Order” is any judgment, decree, or order (including approval of a settlement agreement) which: (1) provides for child support with respect to a Member's child under the Agreement or provides for health benefit coverage to such child, is made pursuant to a State domestic relations law (including community property law), and relates to benefits under the Benefits Agreement; or (2) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

Contact Member Services if You would like to see a complete copy of the procedures for determining whether an order constitutes a QMCSO.

1.94 “Reconstructive Surgery”

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) For the purpose of Coverage under the Plan, Reconstructive Surgery on the opposite breast to restore symmetry, including Prosthetic Devices/implants or reduction mammoplasty, is included in this definition.

1.95 “Retiree”

A former Eligible Employee of the Group who meets the Group's definition of retired employees to whom the Group offers Coverage under this COC.

1.96 “Rider”

Any description of additional Covered Health Services attached to the Agreement. Health Services provided by a Rider may be subject to payment of additional

Premiums. Riders are effective only when issued by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those that are specifically amended.

1.97 "Schedule of Covered Services"

Description of Covered Services contained in the chart in Section 6.

1.98 "Semi-private Accommodations"

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available and when an exception has been made by the Medical Director in advance of the admission. Exceptions may or may not be granted by the Plan.

1.99 "Service Area"

The geographic area served by the Plan.

1.100 "Skilled Nursing Facility (SNF)"

A facility which provides inpatient skilled nursing care, rehabilitation services or other related Health Services; and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged which furnishes primarily Custodial Care, including training in activities of daily living.

1.101 "Special Enrollment Period"

The period set forth in Section 3.5 of this COC.

1.102 "Specialty Care Physician/Specialist"

A Physician who provides medical services to Members within the range of a medical specialty.

1.103 "Subscriber"

The Eligible Employee or Retiree who has elected the Plan's Coverage for himself and any eligible Dependents through submission of an Enrollment/Change Form and for whom, or on whose behalf, Premiums have been received by the Plan.

1.104 "Total Disability"

Complete inability of the Member to perform all of the substantial and material duties of his or her regular gainful occupation, or complete inability of the Member to engage in gainful employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete inability of the Member to engage in most of the normal activities of a person of like age and gender. The

disability, for Subscriber or Dependent, must require regular care and attendance by a Physician who is someone other than an immediate family member.

1.105 "Urgent Care Appeal"

An Appeal that must be reviewed under an expedited Appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize:

- The life or health of the Member; or
- The Member's ability to regain maximum function.

An Urgent Care Appeal also is an Appeal involving:

- Care that the treating Physician deems urgent in nature; or
- The treating Physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

1.106 "Urgent Care Services"

A condition that requires care which is an unexpected Illness or Injury that requires prompt medical attention. Examples of Urgent Care conditions include fractures, lacerations or severe abdominal pain. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

Urgent Care Services received while You are outside of the Service Area are Covered when the requirements explained Section 7 of this COC are followed. If these requirements are not followed Medically Necessary Urgent Care Services will be Covered at the lower Out-of-Network level of benefits.

If possible, contact Your Physician prior to receiving services to ensure that the Urgent Care Services will be Covered. However, failure to notify Your Physician will not result in denial of Coverage. The records of Your Urgent Care visit will be reviewed against the criteria as defined in Section 1.40 of this COC. If Medically Necessary follow-up care related to the initial Urgent Care Service is required, please contact Your Physician to be eligible for the In-Network level of benefits.

If a condition requiring Urgent Care develops, a Member may go to the nearest Urgent Care center or Physician's office. The Plan will provide Coverage at the In-Network benefit level for a condition requiring urgent care that occurs when the Member is temporarily out of the Service Area under the following conditions:

- The Member's medical condition does not permit the Member's return to the Service Area for treatment; and

- The reason for being outside the Service Area is for some purpose other than the receipt of treatment for a medically related condition.

When this occurs, services will be Covered until the medical condition permits travel or transport back to the Service Area. However, the Plan must be notified by the Member of the treatment within forty-eight (48) hours, condition permitting.

If you are a Member attending college outside of the Service Area, you are required to return to the Service Area and obtain routine and follow-up care from Participating Providers to be eligible for payment at the In-Network benefit level for those Health Services.

1.107 “You or Your”

A Member Covered under this COC.

SECTION 2

USING YOUR BENEFITS

2.1 Membership Identification (ID) Card

Every Member receives a membership ID card. Carry Your ID card with You at all times, and present it whenever You receive Health Services. If Your ID card is missing, lost, or stolen, contact the Member Service Department at the telephone number or web site listed in the Schedule of Important Numbers to obtain a replacement. If Your Dependents are Covered, You will receive one or more additional ID card(s). Enrolled Dependents are listed on ID cards. Your ID card is needed so Providers will bill the Plan and not You for charges other than Copayments, Coinsurance, and non-Covered Services. Each Member must show his or her ID card every time Health Services are requested from Providers. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers have no way of knowing that You are part of the Plan, and You may receive a bill for Health Services.

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

2.2 Health Services Rendered by Providers

Subject to the terms, conditions, exclusions and limitations of the Agreement, a Member is entitled to Coverage for Health Services described in this COC and the Schedule of Benefits if such services (a) are Medically Necessary and (b) are provided by or under the direction of Your Provider and (c) Authorized in advance on behalf of the Plan. (See Section 6, Covered Services, for information on the services requiring Authorization.) The telephone number for prior Authorization is stated in The Schedule Of Important Telephone Numbers And Addresses, which is attached to this COC, and on the back of any Member's ID card. Please remember that as a Member of a PPO plan, you have the option of receiving your Health Services on either an In-Network basis from Participating Providers or on an Out-of-Network basis from Non-Participating Providers. However, benefits for Health Services rendered by a Non-Participating Provider will be paid at a lower level than those rendered by a Participating Provider. If you consult an Out of Network Provider, the difference between the Plan's Out of Network Rate and the Provider's billed charges does not apply to the Deductible. Participating Providers are contractually obligated to file all claims for You.

With respect to transplants, subject to the terms, conditions, exclusions and limitations of the Agreement, a Member is entitled to transplants as described Section 6 of this COC and the Schedule of Benefits if such transplants (a) are

Medically Necessary and (b) [ordered by a Designated Transplant Network Physician and (c) provided at or arranged by a Designated Transplant Network Facility and (d)] Authorized in advance on behalf of the Plan in accordance with the Plan's transplantation guidelines. The telephone number for prior Authorization is stated in The Schedule Of Important Telephone Numbers And Addresses, which is attached to this COC, and on the back of any Member's ID card.

In order to access Your In-Network Benefits You must select a Participating Provider. It is Your responsibility to ensure that the Provider is Participating with Your Plan. This is true for each Provider from whom You may receive Health Services in the course of an entire treatment plan. For example, if You need Health Services and want the highest level of Coverage, You must utilize a Participating Physician. After the Participating Physician has examined You, he or she may recommend that You see a particular specialist. That specialist may or *may not* be a Participating Physician. If You accept the recommendation, and the specialist is not a Participating Physician, then the Health Services You received from the first Physician would be Covered at the (higher) In-Network Benefit level, and the Health Services You received from the specialist would be Covered at the (lower) Out-of-Network Benefit level. Additionally, Providers do not have the authority to independently bind the Plan to Coverage for non-Covered medical services.

In the event that specific Health Services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses at the In-Network level for Medically Necessary Health Services obtained through non-Participating Providers if Authorized in advance through the Plan. A Member is entitled to benefits at the In-Network benefit level for Health Services from a Non-Participating Provider only in the case of an Emergency or if a particular Medically Necessary Health Service is not available from a Participating Provider. When Health Services are not available from a Participating Provider, the Plan shall make a referral to an appropriate Provider, pursuant to a treatment plan approved by the Plan in consultation with Your Physician, the Non-Participating Provider and the Member or the Member's designee. The Member will incur no additional cost beyond what the Member would otherwise pay for Health Services received from a Participating Provider.

Coverage for Health Services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment specified for any service.

2.3 Prior Authorization

It is Your responsibility to ensure all Prior Authorizations have been obtained prior to receiving services. A verbal Authorization will be confirmed by written Authorization, facsimile transmission, or verbally by means of an Authorization number. Prior Authorization is required for, but is not limited to the following Health Services:

- Referrals to certain Specialists;
- Non-Emergent or Urgent inpatient Hospital admissions and related services, including observation;
- Health care facility admissions other than Hospitals (including, but not limited to, SNF, hospice, and rehabilitation services);
- Outpatient surgical procedures (except tubal ligation, vasectomy performed in a Physician's office, breast biopsy by needle aspiration);
- Certain outpatient diagnostics (including any angiography/cardiac catheterization, magnetic resonance imaging procedures (MRI), CT scans, PET scans, and radio frequency ablation);
- Rehabilitation/therapy: cardiac, occupational, physical, pulmonary, speech;
- Mental Health and Substance Abuse Services;
- Ancillary services (including Home Health Care Services, home hospice care, non-Emergency ambulance transfer, DME, Orthotics, and Prosthetics);
- Pain management, including epidural, facet and trigger point injections;
- Infertility Services;
- All pregnancy related services;
- Accident-related dental services to Permanent Sound Natural Teeth;
- Injectable and self-injectable medications;
- Lesion removal in office or facility; and
- Transplants (all phases).

Additional Health Services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All Health Services identified in this COC are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider obtains an Authorization.

Please refer to Section 6 for a complete list of Health Services requiring Prior Authorization.

2.4 Second Opinion Policy

A Member may seek a second medical opinion or consultation from other Physicians at no additional cost to the Member beyond what he would otherwise pay for an initial medical opinion or consultation. In the event that Member chooses to seek a second medical opinion and the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, then the Plan will arrange for a referral to a Physician with the necessary expertise to provide a second medical opinion. In such a case, the Member shall obtain the second medical opinion at no greater cost than if the benefit were obtained from a Participating Provider. The Member may also solicit a second opinion from a Non-Participating Physician of his choice. In this case, the second opinion visit will be Covered at the lower Out-of-Network level of benefits. Second medical opinions or consultations will be subject to all of the terms, conditions, exclusions and limitations of the Plan.

2.5 Authorization

Coverage for certain Health Services set forth in the Schedule of Benefits obtained requires prior Authorization through the Plan. Members are responsible for verifying that the requested Health Services are Covered under their Plan, and the required prior Authorization has been granted before receiving the Health Services. For all other care, You may make an appointment directly with the designated Provider to obtain the Covered Services unless an Authorization is otherwise required in the Schedule of Covered Services. **To receive Coverage at the In-Network benefit level for Health Services from a Provider referred by Your Physician, it is Your responsibility to confirm participation in the Plan.**

The Plan will not retract an approved Authorization after the Health Service has been provided unless:

- Such Authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
- The health benefit plan terminates before the Health Service is provided; or
- The Member Coverage under the Plan terminates before the health care services are provided.

Participating Providers do not have the authority to independently bind The Plan to Coverage for medical services that are not Covered Services as described in this COC or mandated by state law. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not Your Participating Provider. To verify Coverage of services or Provider participation status, please contact Member Services.

2.6 Copayments, Coinsurance, and Deductibles

You are responsible for paying Copayments, Coinsurance, and/or Deductible to Providers at the time of service. You must pay Deductible amounts before

applicable benefits will be reimbursed to Providers on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits.

A copayment may be either a defined dollar amount or a percentage of Eligible Expenses. The total amount a Member pays in Copayments is subject to an Annual Out-of-Pocket Maximum, as described in the Schedule of Benefits.

2.7 Out-of-Network Rates

Except for Emergency services;

The Out-of-Network Rate for claims processed by the Plan shall be the lesser of the Non-Participating Provider's billed charges or the current Medicare fee schedule as determined by the Plan for the services and supplies rendered. If there is no corresponding Medicare rate for the particular service, the Out-of-Network Rate will be determined by the Plan.

The Out-of-Network Rate for non-facility claims processed by the Plan's behavioral health vendor shall be the lesser of the Non-Participating Provider's billed charges or the current Medicare fee schedule as determined by the Plan for the services and supplies rendered. If there is no corresponding Medicare rate for the particular service, the Out-of-Network Rate will be determined by the Plan.

The Out-of-Network Rate for facility claims processed by the Plan's behavioral health vendor shall be the lesser of the Non-Participating Provider's billed charges or the average amount the behavioral health vendor pays its Participating Providers for the same service(s).

For Emergency services, the Out-of-Network Rate for claims processed by the Plan shall be the Non-Participating Provider's billed charges.

You are responsible for charges that exceed the Plan's Out-of-Network Rate for Non-Participating Providers. This could result in You having to pay a significant portion of Your claims. Balances above the Out-of-Network Rate do NOT apply to Your [Deductible] [or] Out-of-Pocket Maximum. Please feel free to contact the Plan regarding the Out-of-Network Rate in such cases.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING. You should be aware that when You utilize the services of a Non-Participating Provider for a Covered Service excluding Emergency services, benefit payments to such Non-Participating Provider are not based on the amount billed. The basis of Your benefit payment will be determined according to Your insurance policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION AS NON-PARTICIPATING PROVIDERS MAY BILL MEMBERS FOR ANY AMOUNT UP TO THE BILLED CHARGE AFTER THE PLAN HAS PAID ITS PORTION OF THE BILL.** Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Coinsurance and

Deductible amounts. Additionally, there may be occasions when You will be required to pay the Non-Participating Provider directly for Covered Health Services rendered. You may obtain further information about the Participating status of Providers and information on out-of-pocket expenses by calling Member Services at the number listed in the Schedule of Important Numbers.

If the amount You are charged for a service is equal to or less than the Out-of-Network Rate, the charges should be completely Covered by Your Out of Network Benefit, except for any Copayment, Deductible and Coinsurance payments You must make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular service, you must pay the excess. For example, assume Your Coinsurance is 20%, the doctor's bill is \$150 and the Out-of-Network Rate is \$100. In this example, the Plan would pay \$80, You would pay Coinsurance of \$20 plus the \$50 in actual charges that exceeds the Out-of-Network Rate. Payments for charges in excess of the Out of Network Rate do not count towards your annual Out-of-Pocket Maximum or Your Deductible.

2.8 Out-of-Pocket Maximum

The Individual Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified Covered Services in a calendar/Contract Year. The Family Out-of-Pocket Maximum is a limit on the amount Your family must pay out of pocket for specified Covered Services in a calendar/Contract Year. The Family Out-of-Pocket Maximum is comprised of the combined charges paid by You and Your family.

Once the Out-of-Pocket Maximum is met, Covered Services are paid without any Copayment or Coinsurance for the remainder of the calendar/Contract Year.

2.9 Maximum Lifetime Benefit

The Maximum Lifetime Benefit payable by the Plan per Member, if applicable, is listed in the Schedule of Benefits.

2.10 Qualified High Deductible Health Plans

If You have a QHDHP, be aware of the following:

- Pharmacy services apply to the medical Deductible. You must satisfy the medical Deductible before benefits apply. Once the Deductible is reached, You may have Copayments and Coinsurance;
- The Deductible does not apply to Preventive Care Services. Benefits apply before the Deductible is satisfied. You may have a Copayment or Coinsurance;
- Copayments do not apply once the Out-of-Pocket Maximum has been reached.

Be sure you consult Your Schedule of Benefits for information regarding Copayments, Coinsurance and Deductibles.

2.11 Participating Provider Terminations

The Plan or a Participating Provider may end his/her/its relationship with the other. The Plan does not promise that any specific Participating Provider will be available to render services to a Member. The Plan or a Participating Provider may end its relationship with the other after having supplied proper notice under applicable law. Upon the issuance or receipt of such a notice, the Plan will provide a written notice within thirty-one (31) days to all Members who are patients seen on a regular basis by the Participating Provider whose contract is terminating.

Notwithstanding the above, if the continuation of care by a terminated Participating Provider is Medically Necessary and in accordance with reasonable medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness, You may continue to be Covered for otherwise Covered Services by that Provider if You are:

1. Under active treatment for a particular Injury or Illness. You will continue to receive Covered benefits from the treating Provider for such Injury or Illness for a period of one hundred twenty (120) days from the date of notice of termination;
2. In the second trimester of a pregnancy to continue care with a treating Provider until completion of postpartum care;
3. Being treated at an inpatient facility. You will be allowed to remain at the facility until You are discharged.

The provisions above shall apply only if the treating Provider or inpatient facility agrees to continue to be bound by the terms, conditions and reimbursement rates of the Provider's agreement with the Plan.

During such period of continuation coverage, You shall not be liable to the Provider for any amounts owed for medical care other than Copayments specified under the terms of the Agreement.

2.12 How to Contact the Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or web site on the back of Your ID card.

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

2.13 Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than the Plan or intermediary, acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the Schedule of Benefits, or fees for non-Covered Services delivered on a fee-for-service basis to You. The Provider Hold Harmless agreement shall not prohibit a Provider, and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to a Covered person. Please be advised that the Provider "hold harmless" language does not apply to Out-of-Network (Non-Participating) Providers.

2.14 Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or substance abuse, or mental Illness does not mean that the procedure or treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this COC, to interpret the benefits of the COC and attached Riders, and other terms, conditions, limitations and exclusions set out in the Agreement in making factual determinations related to the Agreement, its benefits, and Members; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Enrolling Unit will be given the proper written notice upon any termination or change in Coverage as required by applicable law. Any termination of the Agreement must be in accordance with Section 5 of this COC. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

2.15 Coverage for Services by Non-Participating Providers

If You wish to request that the Plan consider reimbursing You for Covered Health Services provided by Non-Participating Providers, You must submit a Non-Participating Provider claim form to the Plan. The Provider may agree to complete and file the claim form for You. If not, You may obtain a Non-Participating claim form from either the Provider or from the Member Services Department. If the claim form is not furnished before the expiration of fifteen (15) days after You

receive notice of any claim under the policy, You shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required. A claim will not be denied based upon the Member's failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan.

SECTION 3
ENROLLMENT AND ELIGIBILITY

3.1 Eligibility

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

- Live or physically work in the Service Area at least twelve (12) months out of the calendar/Contract Year unless on temporary work assignment of six (6) months or less; and
- Be an Eligible Employee of the Group; or
- Be a Retiree of a Group with 50 or more Eligible Employees; and
- Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of his/her own status with the Group, and not by virtue of dependency; and
- Meet any eligibility criteria specified by the Group and approved by the Plan, including, without limitation, the criteria set forth in the Group Enrollment Agreement; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

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

- Live in the Plan Service Area at least nine (9) months out of the year, except as permitted under Section 5.1.5, and
- Be the lawful spouse of the Subscriber or be a child of the Subscriber or the Subscriber's spouse including:

Children up to the age of twenty-six (26) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;

Children under age twenty-six (26) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to Qualified Medical Child Support Order;

Children under age twenty-six (26) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian; and

Children twenty-six (26) or older who are either the birth or adopted children of the Subscriber or the Subscriber's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Subscriber upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age twenty-six (26) and annually thereafter.

Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction. A domestic partner qualifies as a spouse under this Agreement only by an attached Rider.

3.2 Change of Group's Eligibility Rules

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

3.3 Persons Not Eligible to Enroll

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

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

3.3.3 Late Enrollees are not eligible to enroll except during the next Open Enrollment Period, unless special enrollment circumstances exist.

3.4 Enrollment

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

3.4.2 Any new employee or employee who transfers into the Plan Service Area may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit a Plan Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Open

Enrollment Period unless there is a special enrollment under Section 3.5.

3.4.3 A special enrollee may enroll with the Plan for Coverage under this Agreement as provided below.

3.4.4 Eligible Employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next Open Enrollment Period, unless they are eligible to enroll as a special enrollee, as described in Section 3.5 below.

3.5 Special Enrollment

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

COBRA continuation coverage that has since been exhausted; or,

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

A situation in which the employee or Dependent incurs a claim that would meet or exceed a Lifetime limit on all benefits offered under the other Coverage.

3.5.2 The employer offers multiple health benefit plans and the employee elected a different plan during an open enrollment period.

Required Length of Special Enrollment. An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other coverage was lost, or in the case where the employee or Dependent has exceeded a Lifetime limit on all benefits offered under the other coverage, no later than thirty (30) days after a claim is first denied due to the operation of a Lifetime limit on all benefits.

Effective Date of Coverage. If the employee or Dependent enrolls within the 31 day period, coverage under the Plan will become effective no later than the first

(1st) day of the 1st calendar month after the date the completed request for special enrollment is received.

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

Non-Participating Employee. An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, court ordered legal guardianship, adoption or placement for adoption of his or her child (even if the child does not enroll).

Non-Participating Spouse. Your spouse may enroll at the time of marriage to You, or upon the birth, court ordered legal guardianship, adoption or placement for adoption of his or her child (even if the new child does not enroll).

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

New Dependents of non-enrolled Employee. A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, court ordered legal guardianship, adoption or placement for adoption may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.

3.5.4 Court Ordered Coverage. A court has ordered coverage be provided for a spouse or minor child under a Covered employee's health benefit plan

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

Effective Date of Coverage. Coverage shall become effective the day of the qualifying event.

3.5.5 Enrollment Pursuant to Termination of Medicaid or SCHIP Coverage. Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in the Plan if either of the following two conditions are satisfied.

- **Termination of Medicaid or SCHIP Coverage.** The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.
- **Eligibility for Employment Assistance Under Medicaid or SCHIP.** The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification. An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage. Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

3.6 Notification of Change in Status.

A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Enrollment/Change Form to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

SECTION 4
EFFECTIVE DATES

4.1 Effective Date

4.1.1 During Open Enrollment Period: An employee or Retiree who is eligible for Coverage under this Agreement and enrolls during a Open Enrollment Period shall be Covered under this Agreement as of the Member Effective Date, a date mutually agreed to by the Plan and the Group.

4.1.2 Newly Hired Employees: A newly hired employee who is eligible for coverage shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage so long as the Plan receives the employee's completed Enrollment/Change Form within thirty-one (31) days of the date that the employee first became eligible for Coverage.

4.1.3 Newly Eligible Employees: An employee of the Group who transfers into the Service Area and had been otherwise eligible for Coverage under this Agreement shall be Covered as of the first (1st) day of the month following the date that he or she first transfers into the Service Area so long as the Plan receives the employee's Enrollment/Change Form within thirty-one (31) days of the date that the employee first becomes eligible for Coverage.

4.1.4 Special Enrollees: Special enrollees shall be Covered under this Agreement as provided in Section 3.5 above.

4.2 Member Effective Date for Dependents

4.2.1 Dependents may be enrolled during an Open Enrollment Period, upon the valid enrollment of newly hired or newly Eligible Employees (as provided in Section 4.1 above). In the case of Dependents who are enrolled during the Open Enrollment Period or upon the valid enrollment of a newly hired or Eligible Employee, the Dependent Effective Date shall be the same as the Member Effective Date.

4.2.2 Dependents who are special enrollees shall be Covered under this Agreement as stipulated in Section 3.5 provided:

- **For Plans delivered in and governed by the laws of the State of Mississippi or Tennessee** - that a child born to You is automatically Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first thirty-one (31) days from the date of birth. In the case of adoption,

the Dependent is Covered from the date of birth or the date of placement, if a petition for adoption is filed within thirty (30) days from the date of birth or placement of the child. Any additional applicable Premiums must be paid for this Coverage to continue beyond the first thirty-one (31) days. Application to add the child as a Dependent must be furnished within thirty-one (31) days from the date of birth.

- **For Plans delivered in and governed by the laws of the State of Arkansas** - that a child born to You is automatically Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. In the case of adoption, the Dependent is Covered from the date of birth or the date of placement, if a petition for adoption is filed within sixty (60) days from the date of birth or placement of the child. Any additional applicable Premiums must be paid. Application and applicable Premiums to add the child as Dependent must be furnished within ninety (90) days.

Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order shall be Covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid Qualified Medical Child Support Order ("QMCSO"). A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan. Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made by such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Enrolling Unit of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Enrolling Unit, the parties may change the required Premium contribution of Subscribers.

SECTION 5
TERMINATION OF COVERAGE

5.1 Conditions for Termination of a Member's Coverage Under the Agreement

Before the first anniversary date of the COC, the Plan may not terminate a Member's Coverage under the COC except for nonpayment of premium. The Enrolling Unit will receive at least thirty-one (31) days' prior notice of any cancellation or termination. Subject to continuation and conversion privileges stated in Section 11 of this COC, Coverage of the Member under the Agreement, including Coverage for Health Services rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

5.1.1 The date the entire Agreement is terminated, as specified in the COC. The Enrolling Unit is responsible for notifying Members of the termination of Coverage under the COC. The fact that the Member has not been notified of the group's termination, shall not be deemed to continue or extend Coverage beyond the termination or non-renewal date of the COC. If Coverage is terminated due to non-payment of Premium, the Plan will provide the Enrolling Unit a grace period of thirty-one (31) days for the payment of any Premium due after the first (1st) Premium payment date. The Coverage may be terminated at the end of the grace period and the services terminated as of the end of the period Covered by the last premium payment. If Covered Services have been rendered during the grace period, the Enrolling Unit will be responsible for either the Premium due or the value of services rendered, or claims for services may be denied by the Plan.

5.1.2 The date specified by the Plan in written notice to the Member that all Coverage will terminate because the Member knowingly provided the Plan with false, material information, including, but not limited to, information relating to another person's eligibility for Coverage or status as a Dependent, or false, material information relating to the Member's basis for obtaining Health Services or health status or that of any Dependent. The Plan has the right to rescind Coverage back to the initial Effective Date when a Member performs an act or omission that constitutes fraud or an intentional misrepresentation of material fact. (Please note that no statement voids the Coverage or reduces the benefits after the Coverage has been in force for two (2) years from its initial Effective Date, unless the statement was fraudulent and contained in a written application). Any other issues may only result in termination of Coverage and denial of related claims. After this policy has been in force for a period of two (2) years during the lifetime of the Member (excluding any period during which the insured is disabled), it shall become

incontestable as to the statements contained in the application.

- 5.1.3** The validity of the policy shall not be contested, except for non-payment of premium, after it has been in force for two (2) years from its date of issue and no statement made by any person covered under the policy shall be used in contesting the validity of the policy during those two (2) years, unless it is contained in a written instrument signed by the person making such statement.
- 5.1.4** The date specified by the Plan in written notice to the Member that Coverage will terminate because the Member permitted the use of his or her ID card by any unauthorized person or used another person's ID card.
- 5.1.5** The date a Member no longer lives or works in the Service Area. The Enrolling Unit or Subscriber is responsible for notifying the Plan of the Member's move from the Service Area. Coverage will terminate on the date of such move, even if the required notice is not provided to the Plan. This Section does not apply to the Dependent child of the Subscriber, as children are not required to live in the Service Area to be enrolled under the Agreement. However, Dependent children who live outside of the Service Area and are enrolled must still follow all the terms and conditions of the Agreement to be Covered for Health Services, except as is otherwise required by federal and state laws and regulations relating to complying with a QMCSO. Members may contact the Plan to coordinate provision of this care as listed in the Schedule Of Important Telephone Numbers And Addresses, or on the back of the Member's ID card.
- 5.1.6** The date the Plan receives written notice from the Subscriber or the Enrolling Unit instructing the Plan to terminate Coverage of the Subscriber or any Member or the date requested in such notice, if later. If the Member receives Covered Services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services, plus its costs to recover such charges, including attorneys' fees.
- 5.1.7** The date the Subscriber is retired or pensioned, unless a specific Coverage classification is specified for retired or pensioned individuals in the application of the Enrolling Unit.
- 5.1.8** The date the Member ceases to be eligible as a Subscriber or Enrolled Dependent, as determined by the Plan. A Member may cease to be eligible if, for example, one of the following events occurs: termination of the Subscriber from Employment, death of the Subscriber, divorce or legal separation from the Subscriber, or loss of Eligibility by an Enrolled Dependent who is a child (due to reaching the limiting age, marrying, or otherwise failing to meet the definition of Dependent). A child who is a Member through a QMCSO, or court ordered legal guardianship, ceases to be eligible on the earliest of the following: a) the date the order is no

longer in effect; or b) the date the child has immediate and comparable Coverage under another plan; or c) the date the employee who was ordered to provide health care Coverage ceases to be an Eligible Employee.

5.1.9 The date the Subscriber or Enrolled Dependent begins serving in the uniformed service and terminates Coverage. The Subscriber or Enrolled Dependent entering uniformed service has the option to continue Coverage. If he or she opts for continuation, Coverage shall remain in effect for up to twenty-four (24) months beginning on the date of the Member's separation from civilian employment or the period of the Member's service in the uniformed service, whichever is the period of lesser duration. The Member may not be required to pay more than 102 percent (102%) of the full Premium. If the Member is on uniformed service duty less than thirty-one (31) days, such Member may not be required to pay more than the employee share, if any, for such Coverage.

5.1.10 Under certain circumstances, Members who cease to be eligible for Coverage under the COC may be eligible to continue Coverage under the COC or to convert to another policy, as described in Section 11 of this COC.

5.2 Termination of Coverage For Members

You shall no longer meet eligibility requirements upon the occurrence of any one of the following events, or upon the Effective Date of the termination notice provided (if applicable) for such event:

- At least thirty-one (31) days notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under this Agreement.
- At least thirty-one (31) days notice of the termination of Your Coverage due to the non-payment of Premiums or supplemental charges (Copayments) required for Hospital or medical services;
- Upon the termination or non-renewal of the Group Enrollment Agreement, by the Group;
- At least thirty-one (31) days written notice if You participate in fraudulent or criminal behavior, including but not limited to:
 - Performing an act or omission that constitutes fraud or intentional misrepresentation if material facts including using Your ID card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

- Allowing any other person to use Your ID card to obtain services. If a Dependent allows any other person to use his or her ID card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his or her ID card to obtain services, the Coverage of the Subscriber and his or her Dependents will be terminated.
- Threatening or perpetrating violent acts against the Plan, a Provider, or an employee of the Plan or a Provider. In this instance, coverage for the Subscriber and all Dependents will be terminated.
- Knowingly makes an intentional misrepresentation of material fact or giving false information on any enrollment application form which is material to a Member's eligibility for Coverage, status as a Dependent, basis for obtaining Health Services, or health status.

5.3 Effect of Termination.

- If Your Coverage under this Agreement is terminated under this Section and other Coverage is not available, all rights to receive Covered Services shall cease as of the date of termination, subject to the provisions in Section 11, Continuation, Conversion, Extensions of Coverage.
- ID cards are the property of the Plan and, upon request, shall be returned to the Plan within thirty-one (31) days of the termination of Your Coverage. ID cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Complaint and Grievance procedures. The Plan may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

5.4 Discontinuation of Coverage

If the Plan decides to discontinue this COC, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued and Your Enrolling Unit will be offered the opportunity, on a guaranteed issue basis, to purchase for You any other coverage offered by the Plan. If the Plan elects to discontinue offering all health insurance coverage in the group market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued

5.5 Certificates of Creditable Coverage.

At the time coverage terminates, loss of Coverage due to reaching the Lifetime maximum as per Your Schedule of Benefits, You are entitled to receive a Certificate of Creditable Coverage verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

SECTION 6

COVERED SERVICES

The Plan covers only those Health Services and supplies that are (1) deemed Medically Necessary, (2) Authorized, if Authorization is required, and (3) not excluded under the exclusions and limitations set forth in Section 8. Health Services are Covered at a reduced or standard percentage under the Out-of-Network benefit outlined in the Schedule of Benefits when Medically Necessary, provided by a Non-Participating Provider, and not excluded as described in Section 7.

The following section, **Schedule of Covered Services**, provides the Health Services and supplies Covered under this Agreement. The schedule is provided to assist You with determining the level of coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in Section 8 and any Copayments, Coinsurance or Deductibles as outlined in Your Schedule of Benefits. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

The differences in Coverage between the In-Network and the Out-of-Network benefit levels, including any Coinsurance, Copayment, or Deductible amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. The Copayment amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. However, if a Member requires Emergency outpatient services and supplies, the required Copayment for Emergency outpatient services and supplies will not apply if Confinement occurs for the same condition within twenty-four (24) hours.

The network of Participating Providers available to You under this Plan is listed in the Provider Directory given to the Enrolling Unit. The Provider Directory is given to Members upon initial enrollment, upon request, and is available on the Plan's web site. It is therefore important that You carefully review Your Provider Directory. Listing a particular Provider in the Provider Directory is not a guarantee that the particular Provider will be participating at the time You seek Health Services. You must verify the participation status of Providers with the Plan before You obtain Health Services.

Except where noted, these Health Services are Covered when rendered by either Participating or Non-Participating Providers. Please remember that Health Services rendered by Non-Participating Providers will be Covered at the lower Out-of-Network level and Authorized if Authorization is required.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions of this COC.

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 51 of 134]

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. Coverage is provided for allergy services and supplies ordered by and provided by or under the direction of a Physician in the Provider's office.	<p>Prior Authorization may be required.</p> <p><u>Exclusions:</u></p> <p>Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.</p>
Ambulance	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered.	<p>Prior Authorization required unless emergent in nature.</p> <p>All air or ground ambulance transfer between facilities requires Prior Authorization.</p> <p><u>Exclusions:</u></p> <p>Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non-Medical Emergency ambulance services are excluded regardless of who requested the ambulance service.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Blood and Blood Products	Covered Service for administration, storage, and processing of blood and blood products in connection with Covered services.	<p><u>Exclusions:</u></p> <p>Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered Service.</p>
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for augmentation and reduction of the affected breast, augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction. In lieu of surgery, Coverage is provided for external Prosthetic Devices.	<p>Prior Authorization required.</p> <p><u>Exclusions:</u></p> <p>Reduction or augmentation mammoplasties unrelated to a Medically Necessary mastectomy.</p> <p>There is no Coverage for surgery performed for removal of breast implants that were originally implanted solely for cosmetic purposes.</p>
Cardiac Rehabilitation Therapy	Covered Service, but limited to treatment for therapy conditions that in the judgment of Your Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	<p>Prior Authorization required.</p> <p><u>Limitations:</u></p> <p>Limited to 36 Phase II visits in a 12-week period.</p> <p><u>Exclusions:</u></p> <p>Phase III (maintenance phase) Cardiac Rehabilitation.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Chemotherapy and Radiation therapy	Standard chemotherapy and radiation therapy, for the treatment of cancer.	<p>Prior Authorization may be required.</p> <p><u>Exclusions:</u></p> <p>Experimental or Investigational or non-standard chemotherapy or radiation therapy.</p>
Child Health Supervision Services	<p>Coverage is provided for the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards, including testing for lead poisoning for children under the age of six (6). Periodic reviews are Covered [(up to 20 visits)]from the date of birth through the age of [twelve][eighteen] years at the following intervals: birth, [two weeks,] two months, four months, six months, nine months, twelve months, [fifteen months,] eighteen months, two years, and yearly after age two years until age [sixteen (16).][six (6) and every two years after age six (6) up to age eighteen (18).]</p> <p>Coverage is also provided for the treatment of autism spectrum disorders for Members under twelve (12) years of age.</p>	
Chiropractic Services	Medically Necessary and clinically appropriate Chiropractic therapy is Covered.	<p>Prior Authorization is required.</p> <p><u>Limitations:</u></p> <p>The therapy rendered must be within the Chiropractor's lawful scope of practice.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Clinical Trials	<p>Coverage for routine patient care costs related to phase I, II, III or IV clinical trials is limited to cancer treatment. The treatment shall be provided in a clinical trial that either:</p> <ul style="list-style-type: none"> • Involves a drug that is exempt, under federal regulations, from new drug application; or • Is approved by the following: <ol style="list-style-type: none"> 1. One of the national institutes of health; 2. The Food and Drug Administration (FDA) in the form of an investigational new drug application; 3. The Veteran's Administration or Defense Department. 	<p><u>Limitations:</u></p> <p>Prior Authorization will be required by the Plan.</p> <p>Coverage is based on the commercial benefit at the time the Member is enrolled in a clinical study at a participating medical center. Should a patient choose to enroll in a study at a non-participating center, Coverage will be limited to the level that would be incurred at the nearest participating center in the Member's Service Area. Any case that can be safely delegated to Participating Physicians, in the event that the Member is receiving care by a Non-participating Provider, will be required to receive the In-Network benefit.</p> <p><u>Exclusions:</u></p> <p>The cost of any non-health care services that a member may require in conjunction with the clinical trial (e.g. transportation, lodging, custodial care) and the administrative costs associated with managing the clinical trial.</p> <p align="right">[Approved] [xx/xx/xx]</p>
-----------------	--	---

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Clinical Trials (cont)	<p>Routine patient care costs are those costs associated with the provision of health care services including services that are:</p> <ol style="list-style-type: none"> 1. Typically provided absent a clinical trial; 2. Required solely for the provision of the drug, medical device or service; 3. Required for the clinically appropriate monitoring of the drug, medical device, or service; 4. Provided for the prevention of complication arising from the provision of the drug, medical device, or service; and <p>Needed for the reasonable and necessary care arising from the provision of the drug, medical device, or service including the complications.</p>	<p>Coverage is excluded for any clinical trials treatment of cancer that are not sanctioned by the listed organizations.</p> <p>Coverage for the cost of investigational drug(s) is excluded.</p> <p>Coverage is also excluded for services not Covered under the Member's policy for non-investigational treatment (e.g. cosmetic surgery, custodial care) or costs in conjunction with the clinical trial (e.g. transportation, lodging, custodial care).</p>
Colorectal Cancer Screening	<p>Coverage is provided for a colorectal cancer screening for Members who are fifty (50) years of age and older, Members who are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines, and Members experiencing symptoms of colorectal cancer as determined by their Physician.</p> <p>Screening shall include:</p> <ol style="list-style-type: none"> 1. An annual fecal occult blood test; OR 2. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; OR 3. A double-contrast barium enema every five (5) years; OR 4. A colonoscopy every ten (10) years. 	
Contraceptive Devices	<p>Contraceptive implants & IUD's are covered. Contraceptive supplies and devices obtained at a pharmacy are determined by the applicable pharmacy Rider.</p>	

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Cosmetic, Plastic and Related Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment. For purposes of this Agreement, psychological or emotional conditions do not constitute Medical Necessity.	Prior Authorization required.
Dental Services	<p>Coverage benefit limited to the Emergency treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums.</p> <p>Services are Covered for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate and Medically Necessary reconstructive surgery of the jaw for repair of traumatic injury.</p> <p>Separate of, and in addition to, the accident-related dental services described above, there shall also be Coverage for the administration of general anesthesia (regardless of whether the dental services are provided in a Hospital, surgical center or Physician's office), and Hospital charges for dental care provided to the following Members when Authorized in advance by the Plan and,</p> <ol style="list-style-type: none"> (1) A child the age of eight (8) or younger; (2) A person who is severely disabled; or (3) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided. 	<p>Limited benefit. Prior Authorization required.</p> <p><u>Exclusions:</u></p> <p>Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia.</p> <p>Removal of teeth due to an Injury, prior to radiation or for radionecrosis is also not a Covered Service.</p> <p>[General anesthesia and facility charges do not apply to treatment of temporomandibular joint disorders.]</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Dental Services (cont.)

Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite,) whether the services are considered to be medical or dental in nature except as provided in this section. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia).

Removal of dentiginous cysts, mandibular tori and odontiod cysts are excluded as they are dental in origin.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Dermatological Services	Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.	<p>Prior Authorization may be required.</p> <p><u>Exclusions:</u></p> <p>The removal or destruction of skin tags is not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment are not Covered.</p>
Dialysis	Covered Service for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	
Diabetic Supplies and Services	<p>Coverage includes Plan approved glucose meters (including those for the legally blind), insulin pumps, infusion devices and appurtenances thereto and self-management training (including medical nutrition counseling) used in connection with the treatment of Type I, Type II and gestational diabetes.</p> <p>Coverage also includes diabetes self-management training as medically necessary provided by an appropriately licensed health care professional.</p>	<p>Prior Authorization required for insulin pens, pumps, cartridges, extended education classes, and glucose meters.</p> <p><u>Limitations:</u></p> <p>Disposable insulin syringes, glucose strips, and lancets are Covered under a Pharmacy Rider (if purchased).</p>
Durable Medical Equipment (DME)	Covered Service when determined to be necessary and reasonable for the treatment of an Illness or Injury, or to improve the functioning of a malformed body part, and when <u>all</u> of the following circumstances apply:	<p>Prior Authorization may be required.</p> <p>Upgrades to equipment are the responsibility of the Member.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Durable Medical Equipment (DME) (cont.)</p>	<p>(1) It can withstand repeated use;</p> <p>(2) It is primarily and customarily used to serve a medical purpose;</p> <p>(3) It is generally not useful to a person in the absence of Illness or Injury;</p> <p>(4) It is appropriate for use in the home; and</p> <p>(5) Member is compliant with its use as prescribed by the treating Physician.</p> <p>There is Coverage for the initial rental and purchase of Durable Medical Equipment when Authorized in advance by the Plan, obtained from a vendor or Provider selected or approved by the Plan, and ordered by or provided by or under the direction of a Provider for use outside a Hospital or SNF. Coverage is provided for Durable Medical Equipment that meets the minimum specifications that are Medically Necessary.</p> <p>Coverage includes, but is not limited to the following: standard wheelchairs; standard Hospital-type beds; Plan approved glucose meters; continuous passive motion devices after surgery; initial placement of elastic garments; oxygen and the rental of equipment for the administration of oxygen; mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators).</p> <p>Coverage will be provided for replacement of Durable Medical Equipment which has become non-functional and non-repairable due to normal, routine wear and tear, medical necessity, or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered.</p>	<p>Exclusions:</p> <p>Durable Medical Equipment that does not serve a medical purpose or cannot be used in a Member's home, equipment that is generally not useful to a person without Illness, Injury or diseases.</p> <p>The purchase or rental of supplies of common household use such as exercise equipment, air purifiers, central or unit air conditioners, allergenic pillows or mattresses and beds.</p> <p>Over-the-counter devices and/or supplies (such as ACE wraps, disposable medical supplies, elastic supports, finger splints, Jobst and TEDS stockings, and soft cervical collars).</p> <p>Advanced versions of devices are not Covered.</p>
--	--	--

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Durable Medical Equipment (DME) (cont.)</p>		<p>Those repairs, replacement, or maintenance costs for any otherwise Covered DME except as provided as a Covered service; maintenance due to normal wear and tear of items owned by the Member; personal comfort items, including air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services. This exclusion also applies to disposable medical supplies, including but not limited to, feeding bags, and feeding syringes.</p> <p>However, modification or replacement costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered if the original equipment was Covered.</p>
--	--	--

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Emergency services	<p>Covered Service as set forth in Section 1.40 and 7.3 below.</p> <p>The Plan definition of "Emergency" is found in the definition section.</p> <p>Services and supplies furnished or required to screen and stabilize an Emergency medical condition provided on an outpatient basis at either a Hospital or an Alternate Facility are Covered. An additional Copayment will not apply if a recurrent Emergency Room visit occurs for the same condition within twenty-four (24) hours.</p>	<p>While Emergency Health Services do not require Prior Authorization from or notification to the Plan, You should notify Your Physician within 48 hours of the onset of the Emergency or the next business day or as soon as physically able.</p> <p><u>Limitations:</u></p> <p>If You are sent to Surgery from the ER and the facility bills as Outpatient Surgery, Your Outpatient Surgery Copayment or Coinsurance may apply. Please refer to Your Schedule of Benefits.</p>
Eyeglasses and Corrective Lenses	<p>Not a Covered Service, except when necessary for the first pair of select eyeglasses or corrective lenses following cataract surgery performed while You are enrolled with the Plan. Coverage is provided for one (1) annual eye examination per Member for the purpose of determining vision loss or disease (including refraction) provided by the Plan's designated vision provider.</p>	<p><u>Limitations:</u></p> <p>Coverage at the in-network benefit level is available only when services are provided by the Plan's designated vision provider.</p> <p><u>Exclusions:</u></p> <p>Those charges incurred in connection with the provision or fitting of eyeglasses or contact lenses, except for initial placement immediately after cataract surgery.</p>
Family Planning	<p>Covered Service includes counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and Norplant and measurement for contraceptive diaphragms.</p>	<p>Prior Authorization may be required.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Genetic Counseling	Covered Services include counseling and routine genetic tests performed by the Plan's reference lab when a Member has delivered or suspected to deliver an infant with suspected genetic abnormalities.	Prior Authorization required. Exclusions: Not covered to diagnose multiple fetuses.
Genomics	Genomics are Covered only by Prescription Rider for the FDA indication and approved dosing.	Limitations: Covered only by Prescription Rider. Must be Prior Authorized by the Plan.
Gynecological Examinations	Coverage is provided for one annual self-referred well-woman examination for each female Member, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society guidelines. Diagnosis, including bone mass measurement, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician. Bone mass measurement is cover testing is Covered only for spine or pelvic testing. Coverage is provided for an annual chlamydia screening for Members the age of twenty-nine (29) and younger.	Exclusions: Peripheral bone mass measurement testing is not Covered.
Health Education	Covered Service includes instructions on achieving and maintaining physical and mental health, and preventing Illness and Injury.	Health education does not require Prior Authorization by the Plan when provided in the Physician's office.
Hearing Screenings	One (1) annual hearing screening per Member for determining hearing loss is Covered. Medically Necessary treatment for hearing loss is also Covered. Hearing aids are Covered up to an amount as specified in Your Schedule of Benefits.	This benefit will be subject to the same durational limits, dollar limits, Copayment, Deductible, and Coinsurance as other Covered services.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Home Health Care Services	<p>Covered Service when <u>all</u> of the following requirements are met:</p> <ul style="list-style-type: none"> (1) The service is ordered by a Physician; (2) Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; (3) Part-time intermittent services are required; (4) A treatment plan has been established and periodically reviewed by the ordering Physician; (5) The services are Authorized by the Plan; and (6) The agency rendering services is Medicare certified and licensed by the State of location; and (7) The Member is homebound. 	Prior Authorization required.
Hospice	<p>Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Member when Authorized by Your Physician. Skilled care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Member and the Member's family for imminent death when the Member has a prognosis of six (6) months or less to live.</p>	Prior Authorization required.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Immunizations	Immunizations are Covered for children pursuant to the Plan's criteria, which uses national standards (approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force) to establish eligibility guidelines. Adult immunizations are Covered as per guidelines of the Center for Disease Control (CDC) and the U.S. Taskforce of Preventive Guidelines. This program is fully compliant with the minimum Coverage requirements of State law. Please refer to the Member Handbook for further information on Covered immunizations.	Prior Authorization required for immunizations other than routine childhood immunizations (e.g., Lyme Disease).
Implants and Related Health Services	Implant devices and related implantation Health Services including penile implants (unless prescribed to treat impotence which is psychological in origin), implants for the purpose of contraception, and implants for the delivery of Prescription Medication when provided by or under the direction of Your Physician, in accordance with the Plan's guidelines and approved in advance by the Plan, are Covered.	<p>Prior Authorization required.</p> <p><u>Limitations:</u> Penile implants are limited to one (1) per Lifetime.</p> <p><u>Exclusions:</u> There is no Coverage for either dental, breast, cochlear (including services related to cochlear implants), or nanometric implants.</p> <p>This list also includes, but is not limited to, VNS (vagal nerve stimulator) implants.</p> <p>Covered implants, except when necessitated due to a change in the Member's medical condition.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Impotence	Medically Necessary treatment for male organic impotence is Covered.	Prior Authorization required. <u>Exclusions:</u> Treatment for male psychogenic impotence.
[Infertility	Medically Necessary diagnostic studies which are related to Infertility are Covered once per Lifetime. Members may self-refer to any obstetrician, gynecologist or obstetrician/gynecologist for Covered services. [Any therapeutic services related to Infertility would only be Covered under an attached Rider to the Agreement, as Coverage for such services is not provided under the Schedule of Benefits.] [Coverage for in vitro fertilization applies only to Plans delivered in and governed by the laws of the State of Arkansas: Coverage for in vitro fertilization when: <ol style="list-style-type: none"> 1. The Member's oocytes are fertilized with the spouse's sperm; and 2. The Member and the Member's spouse have a history of unexplained infertility of at least two (2) years duration; or 3. The infertility is associated with endometriosis, exposure in utero to Diethylstilbestrol (DES), blockage of or removal of one of both fallopian tubes not a result of voluntary sterilization, or abnormal male factors contributing to the infertility; and Member has been unable to obtain a successful pregnancy through less costly infertility treatment.]	Prior Authorization required. <u>Limitations:</u> Benefit is limited to \$15,000 per Lifetime.] <u>Exclusions:</u> Therapeutic services and treatment related to Infertility are not Covered except by an attached Rider to the Agreement.]]

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Injectable Medications	<p>Medically Necessary injectable medications are Covered when FDA-approved and medically appropriate, subject to limitation by pre-Authorization and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.</p> <p>For Coverage of medications that are self-injectable, please see "Self-Injectable Medications" in this Section.</p>	Prior Authorization required.
------------------------	---	-------------------------------

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Inpatient Hospital Care</p>	<p>Coverage includes: general nursing care; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in Hospital; laboratory and X-ray examinations; electrocardiograms; Semi-private Accommodations, Intensive Care Unit, and Coronary Care Unit.</p> <p>Consistent with the Plan's utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay.</p> <p>Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, Your Provider will be notified that Coverage will cease.</p> <p>Certain Health Services rendered during a Member's Confinement are subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.</p>	<p>Prior Authorization required unless Emergency admission.</p> <p>Exclusions:</p> <p>Except where the Plan has given specific Authorization, You must be admitted to a Participating Hospital and be under the care of a Participating Provider to be eligible to receive In-Network level of benefits for non-Emergency Covered Services.</p> <p>Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.</p> <p>Additional elective, not Medically Necessary surgical procedures are not Covered.</p>
<p>Laboratory Services:</p>	<p>Covered Service.</p>	<p>You may have a Copayment, Coinsurance and Deductible depending on Your benefits. Please refer to Your Schedule of Benefits.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Mastectomy	<p>Medically Necessary mastectomies are Covered. Coverage includes a hospital stay of not less than forty-eight (48) hours unless a shorter length of stay is requested by the member in consultation with the attending Physician. If a Member elects breast reconstruction following a Medically Necessary mastectomy, the following benefits are also Covered:</p> <ul style="list-style-type: none"> • Reconstruction of the affected breast; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • Prostheses; and • Treatment of physical complications at all stages of the mastectomy, including lymphedemas. 	Prior Authorization required.
------------	---	-------------------------------

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Maternity Services</p>	<p>Members may self-refer to any obstetrician, gynecologist or obstetrician/gynecologist for Covered services. Maternity-related medical, Hospital and other Covered Health Services are treated as any other illness. Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery.</p> <p>These periods, if approved by the Physician in consultation with the mother, may be shortened. If there is a shorter length of stay, there will be Coverage for post-discharge care. This care shall consist of a minimum of two (2) visits at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a Physician.</p> <p>Testing for lead poisoning for pregnant women is a Covered benefit.</p> <p>Pre-natal HIV testing is Covered.</p> <p>Cover is included for the prevention of Perinatal Group B Streptococcal Disease as per recommendation by the Centers for Disease Control.</p>	<p>Notification and Authorization required if You stay beyond 48 hours after a vaginal delivery or 96 hours after a caesarian section delivery.</p>
---------------------------	--	---

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Medical Complications	Complications arising from Medically Necessary surgery regardless of the membership status at the time of surgery.	<p>Prior Authorization Required.</p> <p><u>Exclusions:</u></p> <p>If complications occurred when You did not follow the course of treatment prescribed by Your Provider, although the requested service may be Medically Necessary, or if the complication is from a non-Covered Service, the requested service will not be Covered, including, but not limited to, complications as a result of a clinical trial or experimental procedure.</p>
Medical Services in a Physician's Office	Coverage is provided for services and supplies ordered and provided by or under the direction of Your Physician in the Physician's office, including preventive medical care such as well-baby care, routine physical examinations, and Immunizations. Certain Health Services provided in a Physician's office are subject to separate benefit restrictions and/or Copayments as described elsewhere in this COC or in the Schedule of Benefits.	

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Mental Health Conditions, Alcoholism and Chemical Dependency Services</p>	<p>Coverage is provided for Medically Necessary treatment of Mental Health Conditions and Chemical Dependency Services through partial or full day outpatient programs or nonresidential inpatient treatment. [Two (2) group psychotherapy sessions may be substituted for one (1) outpatient visit.]</p> <p>As an alternative to hospital inpatient days, if less costly residential treatment, partial hospitalization, or crisis respite care for the patient is appropriate, the Plan shall provide for this care at the rate of two (2) alternate care days to one (1) day of inpatient hospital treatment.</p> <p>See Your Schedule of Benefits for information.</p> <p>CHL contracts with a Mental Health and Substance Abuse Designee to coordinate, determine Medical Necessity, and Prior Authorize the diagnosis and treatment of all Mental Health Conditions.</p>	<p>Prior Authorization from the Plan's Mental Health and Substance Abuse Designee is required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.</p> <p>Exclusions:</p> <ol style="list-style-type: none"> 1. Marital, family, educational, or training services unless Medically Necessary and clinically appropriate. 2. Services rendered or billed by a school or halfway house. 3. Care that is custodial in nature. 4. Services and supplies that are not immediately nor clinically appropriate. 5. Treatments that are considered experimental, investigational, controversial or unproven services, treatments, devices, or pharmacological regimens including, but not limited to, Methadone treatment.
--	--	--

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Newborn Care	<p>The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn's condition.</p> <p>Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU), hypothyroidism, galactosemia, [sickle cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.] [and such other common metabolic or genetic diseases that would result in mental retardation or physical dysfunction.]</p> <p>Routine nursery care for a well newborn child is covered up to five (5) full days or until the mother is discharged whichever is the lesser period of time.</p> <p>Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.</p>	Prior Authorization is required for non-emergency or non-urgent transportation to another facility.
Nutritional Counseling	Covered Service when: (1) provided by a Registered Dietician or a Physician and (2) in connection with diabetes, coronary artery disease and hyperlipidemia.	
Oral Surgery and Diseases of the Mouth	<p>Coverage includes only Authorized oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.</p> <p>Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.</p>	<p>Prior Authorization required.</p> <p><u>Exclusions:</u></p> <p>Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis is not a Covered benefit.</p>

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Outpatient Diagnostic Tests and Therapeutic Treatments	Coverage includes services and supplies for prescheduled diagnostic tests and therapeutic treatments provided under the direction of Your Physician at a Hospital or Alternate Facility.	Prior Authorization may be required.
Outpatient Surgery	Coverage is provided for services and supplies for Emergent, Prior Authorized, and prescheduled outpatient surgery provided under the direction of Your Physician at a Hospital or Alternate Facility.	Prior Authorization required.
Pelvic Examinations and Pap Smears	Coverage is provided for a self-referred pelvic examination and cervical screening for asymptomatic women, in accordance with the American Cancer Society guidelines.	
Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Formula/Food	<p>For Plans delivered in and governed by the laws of the State of Mississippi or Tennessee:</p> <p>Formula prescribed by Your Physician to treat PKU and other amino and organic acid inherited disease is Covered for Members under the age of six (6) if Medically Necessary and not intended merely as a convenience for the Member of the family to adhere to a dietician directed low protein diet.</p> <p>For Plans delivered in and governed by the laws of the State of Arkansas:</p> <p>Coverage is provided for medical foods and low protein modified food products for treatment of a Member diagnosed with PKU, galactosemia, organic acidemias and disorders of amino acid metabolism if:</p> <ol style="list-style-type: none"> 1. The products are medically necessary and prescribed and administered under the direction of a licensed Physician; and 2. The cost of the food and food products for a Member exceeds the income tax credit of \$2,400. 	Prior Authorization required.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Podiatry	<p>Covered Service when determined to be Medically Necessary.</p> <p>Covered Service for regular foot exams if You have diabetes, or when otherwise determined to be Medically Necessary.</p>	<p>Prior Authorization may be required.</p> <p><u>Exclusions:</u></p> <p>Foot care in connection with clipping nails or treating corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus). Shoe inserts or Orthotics are also excluded.</p>
Preventive, Diagnostic and Treatment Services	<p>Office visits to Your Physician for Covered Services and includes:</p> <p>Preventive care, including well-baby care and periodic check-ups according to the preventive care guidelines adopted by the Plan. The Plan's guidelines are available in your Member Handbook, on the Plan's website or from Member Services upon request.</p> <ul style="list-style-type: none"> • Diagnosis and treatment of Illness or Injury. • Consultations with Specialists. • Laboratory tests <p>Obstetrical care, including prenatal, delivery and postpartum care, including inpatient care and a home visit in accordance with the medical criteria. Criteria is outlined in the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.</p>	

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Preventive, Diagnostic and Treatment Services (cont.)	<p>Prostate Specific Antigen (PSA) test, and digital rectal examinations, for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is medically necessary.</p> <p>[Colon cancer examinations and tests per American Cancer Society or the United States Preventive Services Task Force guidelines for screening of colon cancer for asymptomatic Members.]</p> <p>A baseline mammogram will be covered for women between thirty-five (35) and forty (40), then every two (2) years, or more frequently based on the recommendation of the woman's physician, for women between forty (40) and fifty (50), and yearly after age fifty (50).</p> <p>Diagnosis, including bone mass measurement,, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician.</p> <p>[Some Covered Services that You receive during a Preventative Service office visit may not qualify as Preventative Services under the Agreement and, consequently, will be subject to applicable Deductibles. In order to be exempt from applicable Deductibles, Preventative Services must qualify as Preventative Services under the Agreement and Section 223 of the Internal Revenue Code.]</p>	
Prostate Screening	Coverage is provided for a prostate-specific antigen (PSA) exam and digital rectal exam for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is Medically Necessary.	

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Prosthetic and Orthotic Devices</p>	<p>Coverage is provided for the initial purchase of Orthotic Appliances and Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. These services must be Authorized in advance by the Plan and obtained for use outside a Hospital or a SNF. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded). Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) device will be Covered. Shoe inserts or Orthotics will be Covered <u>only</u> if the Member has diabetes to prevent complications associated with diabetes OR the Orthotic is needed for a shoe that is part of a brace.</p> <p>Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to normal, routine wear and tear, Medical Necessity or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered.</p>	<p>Prior Authorization required.</p> <p>If You require refitting and a replacement due to structural change in anatomy, the replacement must be Prior Authorized.</p> <p><u>Exclusions:</u></p> <p>No Coverage is provided for repair, or duplicates nor is Coverage provided for Health Services related to any repair. Over the counter braces, splints and Orthotics are not Covered. Advanced versions of devices are not Covered. Orthopedic shoes are not Covered. Cranial helmets are not Covered, unless the congenital defect of the skull adversely effects normal brain, auditory, visual or central nervous system development. Shoe inserts are not Covered unless the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace.</p>
--	--	--

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
-------------------	--------------------------------	---

Prosthetic and Orthotic Devices (cont)	<p>Orthotics and Prosthetics will be replaced <u>yearly</u> for documented growth in a child requiring replacement, <u>but not for changes due to obesity.</u></p> <p>Eye Prosthetics will be Covered for replacement every five (5) years with exceptions allowed when documentation supports Medical Necessity for more frequent replacement. Polishing and resurfacing is Covered on a yearly basis.</p>	
Pulmonary Rehabilitation Therapy	Covered Service, but limited to treatment for conditions that in the judgment of Your Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	<p>Prior Authorization required.</p> <p><u>Limitations:</u></p> <p>Limited to one treatment program up to a maximum of 36 visits.</p>
Radiology	Covered Service.	Prior Authorization is required for CAT scans, MRIs, and PET scans.
Reconstructive Surgery	<p>Covered Service for Medically Necessary:</p> <ul style="list-style-type: none"> • Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body; or • Surgery that substantially improves functioning of any malformed body part. 	Prior Authorization required.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Rehabilitation Services and Supplies</p>	<p>Coverage is provided for short-term inpatient or outpatient (whichever is Medically Necessary) rehabilitation services which are expected to result in significant functional improvement within sixty (60) days of the Member's condition, limited to physical therapy, occupational therapy, and speech therapy. Rehabilitation services are limited to services that are Medically Necessary and will result in significant functional improvement of a Member's condition through short-term therapy as determined by a Your Physician and the Plan's Medical Director.</p> <p>Rehabilitation services include physical therapy, occupational therapy, and speech therapy, and are Covered Services up to a maximum of twenty (20) Medically Necessary visits per therapy per calendar/Contract Year. Outpatient rehabilitation services must be provided under the direction of Your Physician and Authorized in advance by the Plan. Coverage includes services, supplies, and related Physician and facility charges.</p>	<p>Prior Authorization required.</p> <p>Exclusions:</p> <ol style="list-style-type: none"> 1. Rehabilitative services provided for long-term, Chronic Medical Conditions. 2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status. 3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain You for employment. 5. Rehabilitative services whose purpose is to treat or improve a developmental or a learning disability or delay, mental retardation, cerebral palsy, or congenital anomalies.
---	---	--

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Rehabilitation Services and Supplies (cont.)</p>		<p>6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.</p> <p>7. Alternative rehabilitation services (e.g., massage therapy).</p> <p>8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.</p> <p>9. Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered.</p>
<p>Second Opinion</p>	<p>Covered Service as per Section 2.4 of this COC.</p>	

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

<p>Services Provided to Residents of Long-term Care Facilities</p>	<p>If the Member is a resident of a long-term care facility licensed by the state or a continuing care retirement community, such Member has the option of receiving the services Covered by this provision in the long-term care facility that serves as the Member's primary residence if the following conditions apply:</p> <ul style="list-style-type: none"> • The facility is willing and able to provide the Covered Service to the Member; • The facility and its Providers meet the requisite licensing and training standards required under state law; • The facility is certified through Medicare; and • The facility and its Providers agree to abide by the terms and conditions of the Plan's contracts with similar Providers, abide by patient protection standards and requirements imposed by state and federal law, and meet the quality standards of the Plan for similar Providers. <p>The services Covered under this provision include, but are not limited to, skilled nursing care, rehabilitative and other therapy services, and post-acute care, as needed.</p> <p>The Plan may utilize Participating Providers to deliver the services Covered under this provision in the Member's resident facility.</p>	<p>Prior Authorization required.</p>
--	--	--------------------------------------

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Your Physician in a Skilled Nursing Facility. Health Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	Prior Authorization required. Limitations: Coverage in a Skilled Nursing Facility is subject to a calendar/Contract Year limitation and medical necessity, as specified in the Schedule of Benefits. Certain Health Services (e.g. lab, x-ray, physical therapy, etc.) rendered during a Member's Confinement are subject to separate benefit restrictions and/or Copayments described elsewhere in this COC or in the Schedule of Benefits.
Surgical Services	Surgical services and other related medical care ordered by and provided by or under the direction of a Your Physician in a Hospital, Participating SNF or Alternate Facility are Covered.	Prior Authorization required. For oral surgery services, see Dental.
Sterilization (voluntary)	Coverage is provided for tubal ligation and vasectomy.	No Authorization required for a vasectomy performed in a Physician's office. Exclusions: Reversal of sterilization is not a Covered Service.
Termination of Pregnancy	Termination of pregnancy after the first trimester is Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term, or if fetal abnormalities incompatible with life are detected.	Prior Authorization required.

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Temporomandibular Joint Disorder (TMJ)	Coverage is provided for the diagnosis and treatment of jaw joint disorders, including TMJ and craniomandibular joint disorder (CMD). Treatment is Covered as per Phase I and surgery under Phase II as defined by the American Dental Association (ADA).	<p><u>Limitation:</u> Prior authorization is required. See Your Schedule of Benefits for additional Coverage information.</p> <p><u>Exclusions:</u> Dental services not related to the diagnosis or treatment of jaw joint disorders.</p>
--	---	---

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Transplants	<p>Services and supplies for certain transplants are Covered at the In-Network benefit level when ordered by a Designated Transplant Network Physician, provided at or arranged by a Designated Transplant Network Facility and Authorized in advance by the Plan in accordance with the Plan's transplantation guidelines. The Member will be notified as to the appropriate Designated Transplant Network Facility and Designated Transplant Network Physician during the Authorization process.</p> <p>[Coverage includes, but is not limited to, treatment of cancer by Medically Necessary dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants as included in the TennCare program.]</p>	<p>A separate authorization is required for each phase of the transplant.</p> <p><u>Limitations:</u></p> <p>There is no Coverage under the Plan's guidelines for transplantation Health Services for the donor under this Plan if the recipient is not a Member.</p> <p>However, if the recipient is a Member, then Health Services and supplies necessary for harvesting for a Covered transplant will be Covered. Coverage for immunosuppressant drugs will be provided under the Member's pharmacy Rider (if purchased).</p> <p><u>Exclusions:</u></p> <p>[Services received at a non-Designated Transplant Network Facility will not be Covered.]</p> <p>Any transplant service deemed Experimental or Investigational will not be Covered.</p>
-------------	---	---

**COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED
BY THE PLAN TO BE MEDICALLY NECESSARY**

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS
--------------------------	---------------------------------------	--

Urgent Care Services	Coverage is provided for Urgent Care Services provided at an Alternate Facility such as an urgent care center or after hours facility.	
Well Child Care, Including Physician Hospital Visits for Newborns	Physician Hospital visits for eligible newborn babies are Covered up to thirty-one (31) days after birth. See Newborn Care in this section. Also included are periodic reviews of a child's physical and emotional status by or under the supervision of Your Provider. Newborns, infants, and children become eligible for these reviews pursuant to the Plan's criteria, which is based on national standards, as defined by the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force. See "Immunizations" in this section for information about child immunizations.	

SECTION 7
OUT OF THE SERVICE AREA

7.1 Confinement in non-Participating Hospital or Hospital Out of Service Area

If the Member is Confined to a Hospital, that Member is required to contact the Plan by calling the number listed either in the Schedule Of Important Telephone Numbers And Addresses, or on the back of the Member's ID card, or arrange for another person to contact the Plan within forty-eight (48) hours from the time the Member seeks treatment for the condition, or as soon as it is reasonably possible. Contact the Plan for information about the Plan's guidelines on transplantation Health Services. You may request a listing of Designated Transplant Network Facilities from the Member Services Department. This listing may be amended from time to time.

7.2 Basic Health Services Rendered Out of Service Area

For purposes of this section, "Basic Health Services" shall mean those services that could reasonably have been foreseen prior to a Member's departure from the Service Area. If the Member receives Basic Health Services out of the Service Area including, but not limited to, maternity services, immunizations, hemodialysis, and scheduled laboratory tests, such Basic Health Services will be Covered at the lower Out-of-Network benefit level. In addition, if a Member travels outside of the Service Area for the purpose of obtaining medical services, those services will not be Covered at the In-Network Benefit Level, unless such service was Authorized in advance by the Plan.

7.3 Emergency for Out of Service Area

When an Emergency occurs outside the Service Area, a Member should seek medical attention immediately from a Hospital, Physician's office or other Emergency facility. The Plan will provide Coverage at the In-Network benefit level for an Emergency that occurs when the Member is temporarily out of the Service Area under the following conditions:

- The Member's medical condition does not permit the Member's return to the Service Area for treatment; and
- The reason for being outside the Service Area is for some purpose other than the receipt of treatment for a non-Authorized, medical condition.

When this occurs, services will be Covered until the medical condition permits travel or transport back to the Service Area. The Member must notify the Plan within forty-eight (48) hours of the onset of the Emergency, or within a reasonable period as dictated by the circumstances. At the request of the Plan, You must make available full details of the Emergency Health Services received. Services provided by an Emergency facility for non-Medical Emergencies are not Covered.

A Member may be transported from outside the Service Area to the Service Area or from a Hospital not affiliated with the Plan to a Participating Provider for continued medical management of an Emergency condition. If the non-Participating Hospital determines that the Member is stabilized, the Hospital and Medical Director (or Medical Director's designee) may confer regarding a decision to transfer the Member to a Participating facility. Air or ground ambulance transportation to return a Member to a Participating Provider is Covered when Authorized by the Plan. If You remain in a non-Participating facility after the Plan has made the appropriate arrangements for transfer to a Participating facility, services rendered by Non-Participating Providers or in non-Participating facilities will not be Covered at the In-Network level of benefits.

IF MEDICALLY NECESSARY FOLLOW-UP CARE RELATED TO THE INITIAL MEDICAL EMERGENCY IS REQUIRED, PLEASE CONTACT YOUR PHYSICIAN. YOU MUST OBTAIN PRIOR AUTHORIZATION TO BE ELIGIBLE FOR THE IN-NETWORK LEVEL OF BENEFITS Follow-up care for Medical Emergency services must be provided, Authorized or referred by Your Physician in conjunction with the Plan. Follow-up care is defined as Medical Necessary treatment related to and rendered within, seventy-two (72) hours of the initial Emergency.

The Plan does not cover at the In-Network benefit level, services and supplies required for treatment which You reasonably could have foreseen prior to Your departure from the Service Area.

SECTION 8
EXCLUSIONS AND LIMITATIONS

The following items are excluded from Coverage both In-Network and Out-of-Network:

- 1) Any service or supply that is not Medically Necessary;
- 2) Any service or supply that is not a Covered service or that is directly or indirectly a result of receiving a non-Covered Service;
- 3) Any service or supply for which You have no financial liability or that was provided at no charge; those Health Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Agreement;
- 4) Procedures and treatments that the Plan determines, in the Plan's sole and absolute discretion to be Experimental or Investigational as defined in Section 1.43;
- 5) Court-ordered services or services that are a condition of probation or parole;
- 6) Those Health Services otherwise Covered under the Agreement related to a specific condition when a Member has refused to comply with, or has terminated the scheduled service or treatment against the advice of a Your Provider or the Mental Health/Substance Abuse Designee;
- 7) Those Health Services otherwise Covered under the Agreement, but rendered after the date individual Coverage under the Agreement terminates, including Health Services for medical conditions arising prior to the date individual Coverage under the Agreement terminates; and
- 8) Those Health Services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as a Member, or rendered by a person who is a member of a Member's family, including spouse, brother, sister, parent, step-parent, child or step-child.
- 9) Health Services for Dependents of a Dependent are excluded except if (a) included specifically by the Group or (b) as set forth in Section 3.1 "Dependent Eligibility".

- 10) The Plan shall not be liable for Coverage of any Health Services to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
- 11) The Plan shall not be liable for any Coverage of any Health Services sustained or contracted in consequence of the Member's being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
- 12) Any medical service that is directly or indirectly the result of receiving a Non-Covered Service, procedure, Prescription Drug, medicine, equipment, or supply including any associated complications, is excluded from Coverage.

Specifically excluded services include, but are not limited to, the following:

- 1) Abortion - Elective Abortions are not Covered. However, complications of elective Abortions will be Covered;
- 2) Acupuncture - Those acupuncture services and associated expenses which include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes;
- 3) Allergy Services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
- 4) Alternative Therapies - Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing, massage
- 5) Ambulance Service - Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non Medical Emergency ambulance services are excluded regardless of who requested the services;
- 6) Augmentative Communication Devices, including but not limited to devices utilizing word processing software and voice recognition software;
- 7) Autopsy - Those services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;
- 8) Behavior modification - Those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-acute head injuries, or cerebral palsy;

- 9) Biofeedback;
- 10) Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;
- 11) Braces and supports needed for athletic participation or employment;
- 12) Care rendered to You by a relative;
- 13) Charges resulting from Your failure to appropriately cancel a scheduled appointment;
- 14) Christian Science Practitioners - Christian Science Practitioners' services are excluded with the exception of the Medicare certified Religious Non Medical Health Care Institutions (RNHCIs) Services. The services and supplies provided by a naturopath are also excluded;
- 15) Cochlear Implants and related services;
- 16) Cosmetic Services and Surgery - Those Health Services, associated expenses, or complications resulting from Cosmetic Surgery are not Covered. Cosmetic procedures include, but are not limited to, pharmacological regimens, plastic surgery, blepharoplasty, and non-Medically Necessary dermatological procedures and Reconstructive Surgery. Cosmetic procedures are those procedures that improve physical appearance, but do not correct or materially improve a patho-physiological function and are not Medically Necessary except when the procedure is needed for prompt repair of accidental Injury or significantly improve the function of a congenital anomaly. Breast reconstruction following a Medically Necessary mastectomy is not considered Cosmetic and is a Covered Service;
- 17) Counseling- Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
- 18) Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists Members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered. Custodial Care also includes any health-related services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing or that do not require continued administration by trained medical personnel;
- 19) Dental Services - Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite) whether the services are considered to be medical or dental in nature except as provided in Section 6 "Covered Services" of this COC. Dental x-rays, supplies and appliances (including

occlusal splints and orthodontia). Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

- 20) Dental Surgery and Implants - Dental implants are excluded. Removal of dentiginous cysts, mandibular tori, and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis or to prevent systemic infection is not a Covered Service;
- 21) Durable Medical Equipment ("DME"), Repairs or Replacement - Those repairs or replacement costs for any otherwise Covered DME; maintenance due to normal wear and tear of items owned by the Member; personal comfort items including, but not limited to air conditioners, humidifiers and dehumidifiers, bathtub assistive devices, wheelchair lifts; athletic equipment. There is also no Coverage for the equipment, device, or appliance if the Member is non-compliant with its' use as prescribed by the Member's Physician.
- 22) Educational Services - Those services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
- 23) Equipment or services for use in altering air quality or temperature;
- 24) Educational testing or psychological testing, unless part of a treatment program for Covered services;
- 25) Elective or Voluntary Enhancement- Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, Cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne, even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar, are not Covered;
- 26) Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;
- 27) Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for Phenylketonuria (PKU) or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;
- 28) Examinations- Those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or

orders or which are conducted for purposes of medical research or to obtain or maintain a license of any type;

- 29) Experimental Services - Those Health Services, associated expenses, or complications resulting from Experimental, Investigational, controversial, or unproven Services, treatments, devices and pharmacological regimens, including, but not limited to methadone treatment. The fact that an Experimental, Investigational or unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or unproven in the treatment of that particular condition. Also excluded are those Health Services and associated expenses for clinical trials that are not deemed to be automatically qualified to receive Medicare coverage except as applicable to state law;
- 30) Exercise equipment;
- 31) Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except for initial placement immediately after cataract surgery;
- 32) Eye Services - Those Health Services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK and other refractive eye surgery;
- 33) Food or food supplements;
- 34) Foot Care - Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus). Nail debridement and clipping (except diabetic members) is also excluded;
- 35) Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age which have been appropriately diagnosed to have a documented growth hormone deficiency. However, this exclusion does not apply to growth hormone therapy for the treatment of Turner's Syndrome or to HIV wasting syndrome;
- 36) Hair analysis, wigs, and hair transplants – Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, wigs, hairpieces and hair prostheses;
- 37) Health and Athletic Club Membership Equipment – Any cost of enrollment in a health, athletic or similar club is not Covered;
- 38) Hearing Services and Supplies Those services and associated expenses for cochlear implants, hearing therapy and any related diagnostic hearing tests, except as provided in Section 6 (Covered Services) or attached Rider;
- 39) Home services to help meet personal, family, or domestic needs;
- 40) Household Equipment and Fixtures- Purchase or rental of household equipment, such as, but not limited to, fitness equipment, air purifiers, central

or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

- 41) Hypnotherapy is not Covered;
- 42) Implant – Health Services and associated expenses for implants are excluded, except as specifically stated in Section 6 “Covered Services” of this COC. There is no Coverage for repair or replacement for any otherwise Covered implant and Health Services related to repair or replacement, except when necessitated due to a change in Member’s medical condition. Penile implants for the treatment of impotence having a psychological origin are not Covered. Dental implants are not Covered;
- 43) Immunizations for travel or employment;
- 44) Infertility Services - Those Health Services and associated expenses for the treatment of Infertility including, but not limited to, artificial insemination, ICSI (intracytoplasmic sperm injection), [in vitro or] in vivo fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection and preparation, non-Medically Necessary amniocentesis, and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered, unless Covered by a Rider;
- 45) Lesions – The removal or destruction of skin tags are not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment;
- 46) Maintenance Therapy - There is no Coverage for Maintenance Therapy;
- 47) Medical Complications – Complications arising directly or indirectly from a non-Covered Service, except complications of an elective Abortion;
- 48) Military Health Services – Those Health Services for treatment of military service-related disabilities when the Member is legally entitled to other Coverage and for which facilities are reasonably available to the Member; or those Health Services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- 49) Miscellaneous Service Charges - Telephone consultations, charges for failure to keep a scheduled appointment or any late payment charge;
- 50) Nanometrics – There is no Coverage for Nanometrics implants;
- 51) No legal obligation to pay - Services are excluded for Injuries and Illnesses

for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and illness. Health Services and supplies furnished under, or as part of a study, grant, or research program are excluded;

- 52) Non-Prescription Drugs – Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded. Take home drugs and medications resulting from an Emergency visit or Hospital stay are Covered;
- 53) Nutritional-based Therapy – Nutritional-based therapies except for treatment of phenylketonuria (PKU) and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;
- 54) Obesity Services - Those Health Services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and Health Services of a similar nature are not Covered. Health Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature are not Covered;
- 55) Occupational Injury- Those Health Services and associated expenses related to the treatment of an Occupational Injury or Illness for which the Member is eligible to receive treatment under any Workers' Compensation or Occupational disease laws or benefit plans;
- 56) Oral Surgery Supplies – Those supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;
- 57) Orthodontia and related services;
- 58) Orthotic Appliances and Prosthetic Devices and Repairs – No Coverage is provided for repair, or duplicates nor is Coverage provided for Health Services related to any repair. Over the counter braces, splints and Orthotics are not Covered. Advanced versions of devices are not Covered. Orthopedic shoes are not Covered. Cranial helmets are not Covered, unless the congenital defect of the skull adversely effects normal brain, auditory, visual or central nervous system development. Shoe inserts are not Covered unless the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace;
- 59) Other Coverage Services – Those Health Services for which other Coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including, but not limited to, Coverage required by

workers' compensation, no-fault automobile insurance or other similar legislation;

- 60) Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces;
- 61) Personal Comfort - Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;
- 62) Physical, Psychiatric, or Psychological Examinations or Testing, Etc.- Those physical, psychiatric, neuropsychological, or psychological examinations or testing, or vaccinations, immunizations, or treatments and associated expenses, when such services are for purposes of obtaining, maintaining or otherwise related to education, employment, insurance, travel, marriage or adoption, senile dementia and Alzheimer's, or relating to judicial or administrative proceeds or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type;
- 63) Prescription Medication - Those prescription medications for outpatient treatment, except as Covered under a Prescription Rider to the Agreement. Specifically excluded from Coverage are:

Non-prescription contraceptive devices (e.g., condoms, spermicidal agents);

Any outpatient prescription drug which is to be administered, in whole or in part, while a Member is in a Hospital, medical office or other health care facility;

Compounded prescriptions whose ingredients do not require a prescription;

Cost for packaging required for drugs dispensed in nursing homes;

Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction;

Drugs and products for smoking cessation (e.g., Nicorette gum and smoking cessation skin patches);

Drugs and products used for Cosmetic purposes;

Drugs and products used for fertility;

Drugs and products used to enhance athletic performance including testosterone gel, and growth hormones;

Drugs used primarily for hair restoration;

Experimental products, or drugs prescribed for Experimental indications, including those labeled “Caution – Limited by Federal Law to Investigational Use”;

Injectable and self-injectable medications, except those designated by the Plan;

Over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, herbal products, oxygen, medicated soaps, food supplements, and bandages);

Legend drugs for which there is a non-Prescription Drug alternative (e.g., OTC);

Prescription Drugs related to a non-Covered Service;

Products not approved by the FDA, medications with no FDA approved indications;

Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children;

Prescription Medications taken for travel;

Replacement prescriptions resulting from loss or theft;

- 64) Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;
- 65) Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;
- 66) Radial keratotomy, LASIK, and blepharoplasty;
- 67) Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with Reconstructive Surgery following a Medically Necessary mastectomy. Breast reduction for male physiologic gynecomastia is also excluded;
- 68) Rehabilitative Services – Maintenance therapy and those rehabilitative services and associated expenses which are not short-term rehabilitative services;
- 69) Robotics;
- 70) Sex Transformation Services – Health Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

- 71) Sexual Dysfunction – Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;
- 72) Skin Abrasion, Etc. Salabrasion, chemosurgery, laser surgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar;
- 73) Skin tags;
- 74) Smoking Cessation Those services and supplies for smoking cessation programs and treatment of nicotine addiction;
- 75) Speech Therapy - Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered, except as provided in Section 6 (Covered Services) or attached Rider;
- 76) Sports Related Services – Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation; personal trainers; braces and Orthotics (including protective braces and devices);
- 77) Stem cell transplants unless Covered by a Supplemental Rider;
- 78) Sterilization Services – Those Health Services and associated expenses related to reversal of voluntary sterilizations;
- 79) Surgery performed solely to address psychological or emotional factors;
- 80) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;
- 81) Syringes - Disposable syringes (except for insulin syringes);
- 82) Third Party Liability - Services for which a third party has liability are excluded, including services Covered by federal, state, and other laws, except as they may apply to federal and state medical assistance programs;
- 83) Transplant Organ Removal – Those Health Services and associated expenses for removal of an organ for the purposes or transplantation from a donor who is not a Member unless the recipient is a Member and the donor's medical Coverage excludes reimbursement for organ harvesting. Also excluded are Health Services and associated expenses for transplants involving mechanical or animal organs;
- 84) Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or

tissue to a non-Covered individual;

- 85) Travel Expenses - Travel or transportation expenses, except ambulance service as specifically described in this Plan, even though prescribed by a Participating Provider, except as specified in Section 6;
- 86) Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as, cerebral palsy and ADD;
- 87) Varicose Veins;
- 88) Vision Aids, Associated Services - Expenses incurred for eyeglasses, lenses or frames; fitting of lenses or frames; orthoptics or vision training; biomicroscopy; field charting or aniseikonia investigation; devices to correct vision; LASIK, radial keratotomy low vision aids and services or other refractive surgery; any service or material not provided by the Plan's Designated Vision Provider, except as provided in a Vision Rider;
- 89) Vision care and optometry services, except as provided in Section 6;
- 90) Vocational therapy;
- 91) War related Illness, Injury, services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You;
- 92) Health Services resulting from war or an act of war;
- 93) Work hardening programs;
- 94) Workers' Compensation Health Services - Payment for services or supplies for an Illness or Injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, Occupational Disease law or other legislation of similar purpose, unless the employer is not required by law to provide such coverage;

The following limitations apply:

- 95) Any services, Hospital, professional or otherwise that are not performed by a Participating Provider will be covered at the Out-of-Network benefit level. In the event that specific Health Services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses at the In-Network level for Medically Necessary Health Services obtained through non-Participating Providers if Authorized in advance through the Plan. This limitation shall not apply for Medical Emergencies or Urgent Care Services rendered at an urgent care center or after hour's facility.
- 96) Benefits will be reduced as follows when a Member does not participate in our Utilization Management Program:

If a Member elects not to request Prior Authorization and Continued Stay Review for inpatient Hospital services or fails to act within the required time

limits, a penalty will be assessed. Any penalty is not applicable to the Out-of-Pocket Maximum.

If other services which require Prior Authorization as stipulated in Section 2.3 are performed without a Prior Authorization, Coverage of those Covered Services will be reduced, subject to any applicable Deductible and Coinsurance. Any payment due to a reduction of benefits does not apply to the Out-of-Pocket Maximum. Any Deductible will be applied prior to a reduction in benefits. See your Schedule of Benefits for additional information.

8.1 Certification of Creditable Coverage

For purposes of applying the Pre-Existing Medical Condition exclusion pursuant to this Section of this Agreement, the following terms will apply:

- 8.1.1** Before the Plan imposes an exclusion period with respect to any Member, the Plan will provide notice to You of the existence and terms of the Pre-Existing Medical Condition exclusion. This notice will include: (a) a description of the affected Member's right to demonstrate "prior Creditable Coverage;" (b) a description of the affected member's right to request a "Certificate of Creditable Coverage" from a prior health insurance plan; and (c) a statement that the Plan will assist the affected member in obtaining such a certificate from any prior health insurance plans.
- 8.1.2** Once the affected Member submits one or more Certificates of Creditable Coverage concerning prior health Coverage, the Plan will determine how much of the Coverage documented therein must be applied towards satisfying the Plan's Pre-Existing Medical Condition exclusion period.
- The period of any such preexisting condition exclusion is reduced by the aggregate of periods of Creditable Coverage applicable to the Member as of the Enrollment Date.
- 8.1.3** If the accuracy of a certificate is contested by the Plan, or a certificate is unavailable when needed, an individual has the right to demonstrate Creditable Coverage by alternate means. This right exists under the following circumstances: (a) an entity failed to provide (or timely provide) the Member a certificate; (b) the Member is not entitled to a certificate from a prior entity (such as when the Member's Coverage with a prior health insurance plan is for a period before July 1, 1996); or (c) the Member needs to demonstrate Creditable Coverage before a certificate is available (such as when the Member has an urgent medical condition that necessitates an immediate determination of his or her Creditable Coverage).

The Plan is required to consider all information that the Plan obtains or that is presented to the Plan in making a determination, based on the

relevant facts and circumstances, whether a Member has Creditable Coverage. The Plan will treat the Member as having furnished a certificate with respect to his or her own Creditable Coverage and with respect to the Creditable Coverage of any Dependents if the member: (a) attests to the period of Creditable Coverage; (b) presents relevant corroborating evidence of some Creditable Coverage during the relevant period; and (c) cooperates with the Plan's efforts to verify the information, including giving the Plan authorization to request a certificate from a prior health insurance plan on the Member's behalf.

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

- 8.1.4** Within a reasonable time following receipt of Creditable Coverage information from the Member, the Plan will make a determination, based on the facts and circumstances as to whether the individual has Creditable Coverage and what portion (if any) of the Plan's Pre-Existing Medical Condition exclusion period will apply to the affected Member. Before the Plan will impose a Pre-Existing exclusion period upon the Member, the Plan will notify the Member of the determination and of the applicable Appeals process.
- 8.1.5** After an affected Member has submitted a Certificate of Creditable Coverage (or other acceptable alternative documentation) to the Plan, the Plan will notify the affected Member in writing (within a reasonable period of time) of the Plan's determination regarding what portion (if any) of the Plan's Pre-Existing Medical Condition exclusion period will be applied to that particular affected Member. The written notice will include: (a) the basis for the Plan's determination; (b) the source and substance of any information on which the Plan relied; and (c) an explanation of the procedures established by the Plan for the individual to Appeal the decision regarding the Pre-Existing Medical Condition exclusion period. (NOTE: The Plan will not provide this second notice if the Plan determines that the Plan's Pre-Existing Medical Condition exclusion period has been "zeroed-out" and does not apply to the Member, due to the length of the Member's prior Creditable Coverage). In addition to the written notice described in this section, the Plan will provide the Member with a reasonable opportunity to submit additional evidence of

creditable coverage. However, if the Plan subsequently determines that the member did not have the claimed Creditable Coverage, the Plan can modify the Plan's initial determination provided that: (a) the notice advises the Member of the right to reconsideration; and (b) until the final determination is made, the Plan act in a manner consistent with the initial determination for the purpose of approving access to medical services.

SECTION 9
CLAIMS AND REIMBURSEMENT

9.1 Participating Provider Expenses

Participating Providers are responsible for submitting a claim form for Eligible Expenses for each Health Service and may not bill Members for Health Services except for applicable Copayments, Coinsurance, Annual Deductibles, and non-Covered Services. In the event a Member is billed by a Participating Provider for Covered Eligible Expenses, the Member should contact the Plan at the telephone number listed on the Schedule of Important Numbers in this Certificate and on the back of Your identification card.

9.2 Notice of Claim.

For services received from Non-Participating Providers that are Covered under the Policy, and for services Covered as at the Out-of-Network benefit level, claims for reimbursement must be submitted in accordance with the procedure set forth in this section.

Written notice must be given to the Plan within thirty (30) days after the occurrence or commencement of any loss covered under the Policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as reasonably possible.

The Plan shall furnish to the person-making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the Plan received notice of any claim under the policy, the person making such claims shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Written proof of loss (i.e. cancelled check, credit card statement) and a completed claim form must be submitted to the Plan within ninety (90) days of the date of the loss. The claim form itself may qualify as proof of loss if the bill has not been paid prior to the filing of the claim. Failure to furnish such proof within the ninety (90) days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within the ninety (90) days, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.

All benefits payable under the policy shall be payable not more than thirty (30) days after receipt of proof that is subject to due proof of loss, and that subject to that proof of loss, all benefits payable under the certificate shall be paid as soon as possible after receipt of such proof.

9.3 Time of Payment of Claims - applies only to Plans delivered in and governed by the laws of the State of Mississippi:

All benefits payable under this Agreement for any loss will be paid within twenty-five (25) days after receipt of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of a clean claim where claims are submitted in paper format. Benefits due under the Agreement and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the Plan receives a clean claim containing necessary medical information and other information essential for the Plan to administer Pre-existing condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by a Plan for adjudication and which requires no further information, adjustment or alteration by the Provider of the services or the Member in order to be processed and paid by the Plan. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the Plan must pay the Provider (where the claim is owed to the Provider) or the Member (where the claim is owed to the Member) interest on accrued benefits at the rate of one and one-half percent (1-1/2%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar (\$1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

9.4 Section Timing

The Plan may accept a late claim if extenuating circumstances prevent the Member from making a claim during the ninety (90) day period. Each Member shall file with the Plan all pertinent information concerning himself or herself as the Plan may require and in the manner and form as the Plan specifies. The Member shall not have any rights or be entitled to benefits unless he or she files the required information. Each Member claiming benefits under the Plan shall supply written proof that Eligible Expenses were incurred or that the benefit is Covered under the Plan. Examples of acceptable proof of loss include a copy of a cancelled check, or a credit card statement. Claim forms may be obtained from the Plan by calling the telephone number listed on the back of Your identification card. If the Plan determines that a Member has not incurred a Covered expense or that the benefit is

not Covered under the Plan or if the Member fails to furnish the requested proof, no reimbursement shall be made to the Member.

In the event of a question or dispute concerning Coverage for Health Services, the Plan may reasonably require that a Member be examined at the Plan's expense by a Physician designated by the Plan during the pendency of a claim and to make an autopsy in the case of death where it is not forbidden by law.

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after proof of loss has been filed and no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy.

9.5 Reinstatement

If any renewal Premium be not paid within the time granted the insured for payment, a subsequent acceptance of Premium by the insurer or by any agent duly authorized by the insurer to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the policy will be reinstated upon approval of such application by the insurer, or lacking such approval, upon the forth-fifth (45th) day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

9.6 Payment to Public Entities

Any benefits payable hereunder to an insured Member shall be payable with or without assignment from the insured to a public Hospital or clinic for services or supplies provided to the insured if a proper claim is submitted by the public Hospital or clinic. Payment to the public Hospital or clinic shall discharge the Plan from any and all obligations and liability to the Member to the extent of the benefits paid. In the event the Plan has already made payment on such charges to the insured prior to receipt of the claim from the public Hospital or clinic, the Plan will not be required to pay the claim to the public Hospital or clinic again.

All other benefits of the policy shall be payable to the person insured.

SECTION 10
COORDINATION OF BENEFITS

10.1 Coordination With Other Plans (other than Medicare)

This coordination of benefits (“COB”) provision applies when a Member has health care Coverage under more than one plan. “Plan” is defined below. The order of benefit determination rules below determine which plan(s) will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the Plan’s total Allowable Expense.

10.2 COB Definitions

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

“Plan” includes: group insurance, closed panel or other forms of group or group-type Coverage (whether insured or uninsured); Hospital indemnity benefits in excess of \$100 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

“Plan” does not include: individual or family insurance; close panel or other individual Coverage (except for group-type Coverage); amounts of Hospital indemnity insurance of \$100 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and Coverage under other governmental Plans, unless permitted by law.

Each contract for Coverage under Section 10.3 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

The order of benefit determination rules determine whether the Plan is a “Primary” Plan or “Secondary” Plan when compared to another Plan covering You or Your Covered Dependent. When the Plan is Primary, the Plan’s benefits are determined before those of any other Plan and without considering any other Plan’s benefits. When the Plan is Secondary, the Plan’s benefits are determined

after those of another Plan and may be reduced because of the Primary Plan's payments.

"Allowable Expense" means a health care service or expense including Deductibles and Copayments, that is Covered, at least in part by any of the Plan's covering You or Your Covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan's Allowable Expenses:

1. If a Member is Confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is otherwise a Covered benefit) is not an Allowable Expense.
2. If a Member is Covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
3. If a Member is Covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.
4. The amount a benefit is reduced because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides

more than one half of the calendar year without regard to any temporary visitation.

“Joint Custody”. If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) 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 Section 10.3.

10.3 Order of Benefit Determination Rules

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

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
2. A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.
4. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.
 - a) Non-Dependent or Dependent. The Plan that covers the Member other than as a Dependent, for example as an employee, member, Subscriber or retiree is Primary and the Plan that covers the Member as a Dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Member as a Dependent; and Primary to the Plan covering the Member as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, Subscriber or retiree is Secondary and the other Plan is Primary.
 - b) Child Covered Under More Than One Plan. The order of benefits when a child is Covered by more than one Plan is:

- i. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - (a) The parents are married;
 - (b) The parents are not separated (whether or not they ever have been married); or
 - ii. If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
 - iii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - iv. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.
 - v. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - (a) The Plan of the Custodial Parent;
 - (b) The Plan of the spouse of the Custodial Parent;
 - (c) The Plan of the non-custodial parent; and then
 - (d) The Plan of the spouse of the non-custodial parent.
5. Active or inactive employee. The Plan that covers a Member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Member is a dependent of a person Covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. Continuation coverage. If a Member whose coverage is provided under a right of continuation provided by federal or state law also is Covered under another Plan, the Plan covering the Member as an employee, member, Subscriber or retiree (or as that Member's

dependent) is Primary, and the continuation Coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer or shorter length of coverage. The Plan that Covered the Member as an employee, member, subscriber or retiree longer is Primary.
8. If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

10.4 Effect On The Benefits of the Plan

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

1. Determine the Plan's obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for You or Your Covered Dependent; and
3. Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Member's benefit reserve to pay up to 100% of the Plan's total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claims Determination Period, the benefit reserve returns to zero (0). A new benefit reserve must be created for each new Claim Determination Period.

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

10.5 Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

- a) If an employee is eligible for Medicare and works for a Group with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding the calendar/Contract Year, then Medicare will be the primary payer. These employees and their spouses who are covered and over 65 must apply for Medicare Parts A, B, and D. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis. If the Member does not apply for Medicare Parts A, B and D, the plan will only pay secondary benefits based on what Medicare would have covered if the Member had applied for Medicare coverage.
- b) If an employee works for a Group with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding the calendar/Contract Year, the Plan will be primary. However, an Employee may decline coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare-Covered services. You will continue to be Covered by the Plan as primary unless You:
 - 1) Notify the Plan, in writing, that You do not want benefits under the Plan; or
 - 2) Otherwise cease to be eligible for benefits under the Plan; or
 - 3) If we determine through some other means that we are not the primary carrier.

Disability

- a) If You are under age 65 and eligible for Medicare due to disability, and actively work for a Group with fewer than 100 employees, then Medicare is the primary payer. The Plan will pay benefits on a secondary basis.
- b) If You are age 65 or older and actively work for a Group with at least 100 employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) the Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

End Stage Renal Disease (ESRD)

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

Coordination of Benefits for Retirees

- a) If You are retired and You or one of Your Dependents is Covered by TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 110 of 134]

Medicare Parts A, B and D (or would have been Covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

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

10.6 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

1. Provide the Plan with information about other coverage and promptly notify the Plan of any coverage changes;
2. Give the Plan the right to obtain information as needed from others to coordinate benefits;
3. Return any excess amounts paid to you to the Plan if the Plan or Your Provider provides a credit or payment and later finds that the other Coverage should have been primary.

10.7 Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan 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.

10.8 Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

1. The persons it has paid; or
2. For whom it has paid; or
3. Insurance companies; or
4. Other organizations.

SECTION 11
CONTINUATION, CONVERSION, EXTENSIONS OF COVERAGE

11.1 Continuation Coverage Under COBRA (Consolidated Omnibus Budget Reconciliation Act) - Continuation Coverage under COBRA shall apply only to Enrolling Units that are subject to the provisions of COBRA. Members should contact the Enrolling Unit's plan administrator to determine if he or she is eligible to continue Coverage under COBRA.

Continuation Coverage for Members who selected continuation Coverage under a prior plan which was replaced by Coverage under the COC shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Sections 11.4 below, whichever is earlier.

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

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

A Member whose Coverage would otherwise end under the COC may be entitled to elect continuation Coverage in accordance with federal law and as outlined in this section, or in accordance with state law and as outlined in Sections 11.5 below. The Member should contact the Enrolling Unit's designated plan administrator to determine whether federal or state continuation applies.

11.2 Qualifying Events for Continuation Coverage Under Federal Law - If the Member's Coverage terminated due to one of the following qualifying events, he or she is entitled to continue Coverage. The Member may elect the same Coverage that he or she had at the time of one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Unit or reduction of hours, for any reason other than gross misconduct; or
- Death of the Subscriber; or
- Divorce or legal separation of the Subscriber; or
- Loss of eligibility by an Enrolled Dependent who is a child; or
- Entitlement of the Member to Medicare benefits; or
- The Enrolling Unit filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is a qualifying event only if there is a substantial elimination of Coverage within one (1) year before or after the

date the bankruptcy was filed.

11.3 Notification of Requirements and Election Period for Continuation Coverage Under Federal Law - The Member must notify the Enrolling Unit's designated plan administrator within sixty (60) days of his or her divorce, legal separation or loss of eligibility as an Enrolled Dependent.

Continuation must be elected by the later of sixty (60) days after the Member's qualifying event occurs, or sixty (60) days after the Member receives notice of the continuation right from the Enrolling Unit's designated plan administrator.

A Member whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Unit's designated plan administrator on, or no later than, the forty-fifth (45th) day after electing continuation.

11.4 Terminating Events for Continuation Coverage Under Federal Law - Continuation under the COC will end on the earliest of the following dates:

11.4.1 Eighteen (18) months from the date continuation began for a Member whose Coverage ended because employment was terminated or hours were reduced, in accordance with qualifying event of section 11.3 of this COC. A Member who is disabled at the time of the qualifying event may extend continuation Coverage to a maximum of twenty-nine (29) months as described below;

11.4.2 Thirty-six (36) months from the date continuation began for an enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an enrolled Dependent child or entitlement of the Member to Medicare benefits, in accordance with qualifying events described in Section 11.3 of this COC. Continuation Coverage for enrolled Dependents of a Subscriber whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Members should contact the Enrolling Unit's designated plan administrator for information regarding the continuation period;

11.4.3 The date Coverage terminates under the COC for failure to make timely payment of the Premium;

11.4.4 The date Coverage is obtained under any other group health plan. If such Coverage contains a limitation or exclusion with respect to any Pre-Existing condition of the Member, continuation shall end on the date such limitation or exclusion ends. The other group health Coverage shall be primary for all Health Services except those Health Services which are subject to the Pre-Existing condition limitation or exclusion;

11.4.5 The date the Member becomes entitled to Medicare, except that this shall not apply in the event the Member's Coverage was terminated because the

Enrolling Unit filed for bankruptcy, in accordance with qualifying event described in Section 11.3 of this COC;

11.4.6 The date the entire Agreement ends; or

11.4.7 The date Coverage would otherwise terminate under the COC.

11.5 Qualifying Events for Continuation Coverage Under State Law - A Member who has been Covered continuously under the COC for a period of not less than three (3) months immediately prior to termination is eligible to continue Coverage for the policy month remaining plus:

- **For Plans delivered in and governed by the laws of the State of Arkansas** - one hundred twenty (120) days, upon payment in advance to the employer of the full group premium.

- **For Plans delivered in and governed by the laws of the State of Mississippi or Tennessee** - three (3) additional months, upon payment in advance to the employer of the full group premium.

11.5.1 A Member is not eligible for state continuation coverage if:

- The group policy was terminated in its entirety, or was terminated with respect to an insured class of which the Member was a participant;
- The Member failed to pay any required contribution;
- The Member is eligible for Medicare; or
- Any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.

11.5.2 Members terminated from group coverage due to divorce or death of an insured spouse are entitled to continuation coverage for the policy month remaining plus an additional fifteen (15) months upon payment in advance to the employer, in three (3) month increments, the full three-month group premium.

11.5.3 Members terminated from group coverage during pregnancy are entitled to continuation coverage for the policy month remaining plus up to six (6) additional months after the pregnancy ends.

11.6 Conversion [- not available for Plans delivered in and governed by the laws of the State of Mississippi]

For Plans delivered in and governed by the laws of the State of Arkansas -

A Member is entitled to conversion Coverage if the group policy was terminated in its entirety or was terminated with respect to an insured class of which the employee was a member. The Member may make application to the Plan for Coverage under a conversion contract without furnishing evidence of insurability.

Upon payment in advance, Conversion coverage shall be continued for the fraction of the month remaining at termination and continue until such time as the Member becomes fully covered under another group policy or contract and all Pre-existing conditions are covered or would be covered under that group policy or contract.

11.6.1 A Member shall not be entitled to conversion coverage if:

- The Member failed to pay any required contribution;
- The Member is eligible for Medicare
- Any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.

For Plans delivered in and governed by the laws of the State of [Mississippi or] Tennessee -

A Member is entitled to conversion Coverage if the group policy was terminated in its entirety or was terminated with respect to an insured class of which the employee was a member. The Member may make application to the Plan for Coverage under a conversion contract without furnishing evidence of insurability provided that the Member has been Covered under this Plan during the entire three (3) months immediately prior to termination. Conversion coverage shall be continued for the fraction of the month remaining at termination plus three (3) additional months upon payment in advance of the premium.

11.6.2 A Member shall not be entitled to conversion coverage if:

- The Member failed to pay any required contribution;
- The Member is eligible for Medicare
- Any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.

11.7 Extension of Coverage if a Member is Confined - The Plan will continue to provide Covered Services if the Group Enrollment Agreement terminates while a Member is Confined. Services will be provided only for the specific medical condition causing that Confinement. This extension of Coverage will end on the earlier of the date that:

- 1) The Confinement is no longer Medically Necessary; or
- 2) The Member exhausts the Covered Services available for that Confinement and/or medical condition; or
- 3) The Member becomes eligible for coverage from another group health benefits policy; or
- 4) Premiums ceases to be paid;
- 5) Twelve (12) months after the termination date of the Agreement.

Any extension of Coverage under this section shall not extend the time period for enrolling for the Coverages described elsewhere in this section.

11.8 Extension of Coverage Upon Total Disability - The Plan will continue to provide Covered Services for You if You are Totally Disabled as of the date of the termination of the Agreement. This extension of Coverage shall only:

1. Provide Covered Services that are Medically Necessary to treat medical conditions causing or directly related to the Total Disability; and
2. Remain in effect until the earlier of the date:
 - You cease to be Totally Disabled; or
 - You have exhausted the Covered Services available for treatment of that condition; or
 - Twelve (12) months from the termination date of the Agreement; or
3. Premium ceases to be paid.

Any extension of Coverage under this section shall not extend the time period for enrolling for the Coverages described elsewhere in this section.

SECTION 12
RESOLVING COMPLAINTS AND GRIEVANCES

Procedures

12.1 Complaints and Inquiries

12.1.1 Investigation Upon Receipt of a Complaint or Inquiry by Telephone: If You have a Complaint or Inquiry, You may submit it by telephone. (See the attached Schedule of Important Telephone Numbers and Addresses.) When this is done, the Member Services representative will make every effort to resolve the issue within one (1) working day. In some cases, however, it may take as long as fifteen (15) working days or more from the date of the call for resolution.

12.1.2 Written Inquiries: You may submit a written Inquiry to the Member Services Department. (See the attached Schedule of Important Telephone Numbers and Addresses.) You will be sent an acknowledgement letter within three (3) working days of the original receipt of the Inquiry. When this is done, you will receive resolution of the Inquiry within thirty (30) calendar days.

12.1.3 Written Complaints: You may submit a Complaint in writing to the Member Services Department. (See the attached Schedule of Important Telephone Numbers and Addresses.) You will be sent an acknowledgement letter within ten (10) working days of the original receipt of the Complaint. The investigation of the Complaint will be completed within twenty (20) working days of original receipt of the Complaint unless you receive notice from the Plan that additional time is required. Within five (5) working days after the completion of the investigation, You and Your Authorized Representative will be notified of the resolution of the Complaint.

12.2 Appeals

12.2.1 Notice of Appeal: If You wish to submit an Administrative Appeal or Medical Necessity Appeal, You should contact Member Services in writing. If You prefer, You may also request information by contacting Member Services by telephone. (See the attached Schedule of Important Telephone Numbers and Addresses.) However, a formal Appeal must be submitted in writing within 180 days of an Adverse Benefit Determination and must include the following information:

- Member name;
- Provider name;
- Date(s) of service;

- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms, why the Member did not contact the PCP, etc.; and
- In cases where the Member's Authorized Representative is appealing on behalf of the member, a completed Member Designated Release of Information form, which can be obtained by calling the Member Services Department

Requesting information by telephone does not constitute filing an Appeal.

If you need a notice in a non-English version, please contact the Member Services Department.

12.2.2 Pre-Service Appeal Review: A pre-service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within fifteen (15) calendar days after the receipt of the **Medical Necessity Appeal**, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision. For Medical Necessity Appeals only, the Plan will inform You of your right to file an Appeal for a second-level review.

Within thirty (30) calendar days after the receipt of an **Administrative Appeal**, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision.

12.2.3 Post-Service Appeal Review: A Post-Service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within thirty (30) calendar days after the receipt of the **Medical Necessity Appeal**, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision. For Medical Necessity Appeals only, the Plan will inform You of your right to file an Appeal for a second-level review.

Within sixty (60) calendar days after the receipt of an **Administrative Appeal**, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision.

Urgent Care Appeal Review: An Urgent Care Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination. For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Plan decision verbally or in writing. Within a reasonable period of time not to exceed thirty-six (36) hours of receiving a valid request for a **Medical Necessity Urgent Care Appeal** or seventy-two (72) hours of receiving a valid request for an **Administrative Urgent Care Appeal**, the Plan will verbally notify You of its decision. For Medical Necessity Urgent Care Appeals only, the Plan will inform You of your right to file an Appeal for a second-level review.

12.2.4 External Review - For Plans delivered in and governed by the laws of the State of Arkansas:

If You or Your Authorized Representative are not satisfied with the decision of the Plan and have exhausted the internal appeal process, You or Your Authorized Representative may request an external review in writing or via electronic media within sixty (60) days after receipt of the Plan's decision. The Independent Review Organization assigned will be chosen from a list compiled and maintained by the Arkansas Department of Insurance.

An External Review is not provided for Adverse Benefit Determinations involving a dispute of a Member's plan eligibility other than disputes that are related to rescission of Coverage.

12.2.4.1 Within five (5) business days after receipt of the request for an external review, You or Your Authorized Representative and treating Physician will be notified in writing whether the request is complete and if the request has been accepted for external review.

- If the request is not complete, the notice will include the

information needed to make the request complete. The additional information must be submitted within seven (7) business days following receipt of the notice.

12.2.4.2 Within forty-five (45) calendar days after receipt of the request for an external review, the Independent Review Organization shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Benefit Determination to You or Your Authorized Representative, treating Physician and the Plan.

- If the Independent Review Organization has overturned any portion or all of the Adverse Benefit Determination, the Plan shall immediately approve the Coverage that was the subject of the Adverse Benefit Determination.

12.2.4.3 You or Your Authorized Representative may request an expedited external review. Within seventy-two (72) hours of the request, the Independent Review Organization will make a decision to uphold or reverse the Adverse Benefit Determination and notify You or Your Authorized Representative, the treating Physician and the Plan. [The Independent Review Organization must provide written confirmation of the decision with forty-eight (48) hours after notice of the decision.]

- An expedited External Review may not be provided for Adverse Benefit Determinations involving a Retrospective Review.

12.2.4.4 Except in the case of a request for an expedited external review, at the time of filing a request for an external review, You or Your Authorized Representative shall submit to the Independent Review Organization a filing fee of \$25 along with the information and documentation to be used by the Independent Review Organization conducting the external review.

12.2.4.5 At any time during the external review process and upon receipt of additional information, the Plan may reconsider its Adverse Benefit Determination.

- The Plan will immediately notify You or Your Authorized Representative, treating Physician and the Independent Review Organization of its decision; and
- The external review process will be terminated if the decision is to reverse the Adverse Benefit Determination.

12.2.5 External Independent Review - For Plans delivered in and governed by

the laws of the State of Mississippi or Tennessee:

12.2.5.1 If Your Medical Necessity Appeal is denied for reasons including, but not limited to: the service, procedure, or treatment is not viewed as medically necessary; denial of specific tests or procedures; denial of referral to specialist physicians; or denial of hospitalization requests or length of stay requests or our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested, You have the right to have the Plan's decision reviewed by an independent review organization ("IRO") not associated with the Plan by submitting to the Plan a written request for a standard external independent review ("Standard EIR"). The procedures for requesting and processing a Standard EIR are set forth below in section 12.2.5.2.

If: 1) You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize the Your ability to regain maximum function; 2) a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but have not been discharged from a facility; or 3) a final adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and Your health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then You or Your Authorized Representative may file a request for an expedited external review ("Expedited EIR"). (Note: an Expedited EIR may not be provided for retrospective adverse or final adverse determinations.) The procedures for requesting and processing an Expedited EIR are set forth below in section 12.2.5.3.

12.2.5.2 Standard External Independent Review Procedures:

Within four (4) months of receipt of an Adverse Benefit Determination or final adverse benefit determination, and You have exhausted Your internal appeal rights, You or Your Authorized Representative may file a request in writing for a Standard EIR.

Within five (5) business days following receipt of Your Standard

EIR request, the Plan will conduct an investigation to determine if Your request for a Standard EIR is complete and eligible for a Standard EIR. Within one (1) business day after the review, You or Your Authorized Representative will be notified in writing:

- whether the request is complete and eligible for a Standard EIR;
- what information to include and/or materials are required for a request which is determined to be incomplete;
- the reasons why, in the case a request is determined to be ineligible for a Standard EIR, the request was found ineligible for Standard EIR review by the Plan and in such case You will be notified of Your right to appeal the Plan's Standard EIR eligibility determination to the Commissioner of the Insurance Department.

Within five (5) business days of the Plan's determination that Your request for a Standard EIR is complete and eligible the Plan will assign an independent review organization from the list of IROs compiled and maintained by the Commissioner of the Insurance Department and notify You or Your Authorized Representative in writing of the eligibility of Your request, its acceptance for external review and the name of the assigned IRO. You or Your Authorized Representative may, within (5) business days from receipt of such notice, submit in writing to the assigned IRO any additional information that You wish the organization consider when conducting the external review. The Plan will also provide to the IRO, within five (5) business days of assignment, those documents and any information the Plan considered in making the adverse or final adverse benefit determination.

Within five (5) days after the date of receipt of all necessary, the assigned IRO shall provide written notice to all the parties of its decision to uphold or reverse the Adverse Benefit Determination or the final adverse benefit determination. Upon receipt of a notice from the IRO reversing the Adverse Benefit Determination or the final adverse benefit determination, the Plan shall immediately approved Coverage.

12.2.5.3 Expedited External Independent Review Procedures:

You or Your Authorized Representative may file a request (orally or in writing) for an Expedited EIR 1) immediately after the date of receipt of a notice prior to a final adverse determination; 2) immediately after the date of receipt of a notice of a final adverse determination; or 3) if the Plan fails to provide a decision on a

request for an expedited internal appeal within 48 hours.

Immediately upon receipt of a request of an Expedited EIR, the Plan will investigate the request to determine if Your request is eligible, notify You or Your Authorized Representative of the eligibility determination.

- If Your request is ineligible, You or Your Authorized Representative will be notified, including Your right to appeal to the Commissioner of the Insurance Department.
- If a determination is made that Your request for an Expedited EIR meets all of the applicable reviewability requirements, the Plan shall immediately assign an IRO to perform an Expedited EIR. Immediately upon assigning an IRO to perform an Expedited EIR, but in no case more than seventy-two (72) hours after assigning the IRO, the Plan shall provide or transmit all necessary documents and information considered in making the final adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

Within two (2) business days after receipt of all pertinent information, the IRO will make a decision to uphold or reverse the final adverse benefit determination and notify the Plan, You and Your Authorized Representative and Your Provider of its decision. If the IRO has reversed the Adverse Benefit Determination or final adverse benefit determination, the Plan shall immediately approved Coverage of the service or supply that was the subject of the adverse or final adverse benefit determination. Should the IRO uphold the adverse or final adverse benefit determination, You have the right to appeal that final decision to the Commissioner of the Insurance Department.

12.2.6 The following Group types – churches, city and county governments – are regulated by state law and are not subject to the Department of Labor regulations. The timeframes for these Appeals are within twenty (20) working days for both Pre and Post Service Appeals. All other timeframes are the same as cited in the preceding sections.

12.2.7 Department of Insurance: The Member, Member's Authorized Representative, or a Physician acting on behalf of a Member has the right to contact the insurance department at any time in this process. The department may be contacted at the number listed in the Schedule of Important Numbers.

SECTION 13
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

13.1 Privacy Information

The Plan needs information about You to manage Your benefits. We collect your information from many sources and keeping your information safe is one of our most important jobs. We make sure that only people who need to use Your information have access to it. We may use and share Your information for:

- Treatment
- Payment
- Health care operations

These uses are covered under state and federal laws. Our policies will reflect the most protective laws that apply to You.

Here are some other ways that we may use or share Your personal information:

- To help providers and other health plans in Your treatment, payment and health care operations.
- To give out information if required by law.
- To other businesses who work for us.
- To tell you about treatment options or health related services.
- To help the sponsor of Your health plan serve You.
- To people You have said may receive Your information.
- To those having a relationship that gives them the right to act on Your behalf.
- To researchers who take all required steps to protect Your privacy.

Other times, we may need to get your permission to use or share Your health information.

13.2 Notice of Privacy Practices

As one of our members, You have certain rights. More information is in the Plan's Notice of Privacy Practices, which You should read. These rights, with some limits, include:

- Asking for restrictions
- Asking for confidential communications
- Asking to see and get copies of Your information

- Asking for corrections to Your information
- Asking for a report of how we may have shared Your information
- Sending a complaint or receiving more information

SECTION 14
GENERAL PROVISIONS

14.1 Applicability

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

14.2 Governing Law

This Plan is delivered and governed by the laws of the State of [Mississippi] [Arkansas] [Tennessee].

14.3 Limitation of Action

Members are encouraged to exhaust the Plan Complaint and Grievance Procedure prior to pursuing legal action, (in a court or other government tribunal) as this is the most expeditious and cost-effective method of resolving Member concerns.

14.4 Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Agreement. Such right to health care service Coverage or other benefits is not transferable.

14.5 Relationship Among Parties Affected by Agreement

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

Neither the Group nor You are agents or representatives of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under this Agreement.

14.6 Contractual Relationships

The Plan agrees with the Enrolling Unit to provide Coverage for Health Services to Members, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Enrolling Unit's Group Enrollment Agreement. This COC is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Group Enrollment Agreement in place between the Plan and the Enrolling Unit, and the Enrolling Unit's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates,

provided the Enrolling Unit is given thirty-one (31) days advance written notice.

The Group Enrollment Agreement between the Plan and the Enrolling Unit may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost that a Member must pay can be obtained from the Enrolling Unit.

This COC is part of the Group Enrollment Agreement as if fully incorporated into the Agreement, and any direct conflict between this COC and the Group Enrollment Agreement will be resolved according to the terms that are most favorable to the Member.

COC's will be provided to the Enrolling Unit by the Plan for distribution to all Members.

14.7 Plan is Not Employer

The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Unit's benefit plan.

14.8 Reservations and Alternatives

The Plan reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by Enrolling Units or Members. You must cooperate with those persons or entities in the performance of their responsibilities.

14.9 Severability

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

14.10 Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this COC. Amendments to the COC are effective upon thirty-one (31) days written notice to the Member or Enrolling Unit. No change will be made to the COC unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change the COC or to waive any of its provisions. Copayment changes shall be made only on the anniversary date of the group's COC unless by mutual agreement of the Plan and the Enrolling Unit

14.11 Waiver

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

14.12 Entire Agreement

This Agreement, including the endorsements and attached papers, shall constitute the entire Agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement shall void or reduce under the Agreement or be used in defense of a legal action unless it is contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the Member. Finally, no such statements, except fraudulent statements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such two (2) year period. After this policy has been in force for a period of two (2) years during the lifetime of the Member (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

Notwithstanding the Schedule of Benefits in this Plan, the Plan may provide different benefits to different Enrolling Units or individuals, as determined by the Plan and applicable Enrolling Units or individuals. Such differences in benefits shall be allowed only as the result of a written Amendment to the Agreement or a written Rider or similar document, approved by the Plan. The Enrolling Unit will notify those Members affected by such different benefits.

14.13 Participation in Policies of The Plan

Any Member who wishes to participate in matters of the Plan's policies and operations may do so by submitting suggestions, in writing, to Member Services at the address on the attached Schedule of Important Telephone Numbers and Addresses. The Member Advisory Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body, pursuant to State law.

14.14 Records

The Member shall furnish the Plan with all medical information and proofs of previous coverage that the Plan may reasonably require with regard to any matters pertaining to this COC in the event the Plan is unable to obtain this information directly from the Provider or insurer.

By accepting Coverage under the COC, each Member, including Enrolled
TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 129 of 134]

Dependents, whether or not such Enrolled Dependents have signed the application of the Subscriber, authorizes and directs any person or institution that has provided services to the Member, to furnish the Plan or any of the Plan's designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Member. The Plan agrees that such information and records will be considered confidential. Upon the Member's consent, the Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning Health Services which are necessary to implement and administer the terms of the COC or for appropriate medical review or quality assessment.

14.15 ERISA

When Coverage under this COC is purchased by the Enrolling Unit to provide benefits under a welfare plan governed by the ERISA 29 U.S.C. § 1001 et seq., the Plan is not the "Plan Administrator" or "Named Fiduciary" of the welfare plan as those terms are used in ERISA. The Plan Administrator and Named Fiduciary is the Employer or Plan Sponsor.

14.16 Examination of Members

In the event of a question or dispute concerning Coverage for Health Services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine a Member at the Plan's expense during the pendency of a claim and to make an autopsy in the case of death where it is not forbidden by law.

14.17 Clerical Error

Clerical error shall not deprive any individual of Coverage under the COC or create a right to additional benefits.

14.18 Notice

Written notice given by the Plan to an authorized representative of the Enrolling Unit is deemed notice to all affected Subscribers and their Enrolled Dependents in the administration of Coverage under the COC, including termination of Coverage. The Enrolling Unit is responsible for giving notice to Members.

14.19 Workers' Compensation

The Coverage provided under the COC does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.

14.20 Conformity with Statutes

Any provision of the COC which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

14.21 Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

14.22 Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by or on behalf of a Member, as required by a State plan for medical assistance approved under title XIX of the Social Security Act. To the extent that payment has been made under such State plan in any case in which the Plan has a legal liability under the Plan to make payment for such Health Services, the Plan will pay for such Health Services in accordance with any State law, provided that the State has acquired such rights to payment.

The fact that a person is eligible for or provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account in enrolling such person, or in determining or making benefit payments under the Plan.

14.23 Policies and Procedures

The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

14.24 Discretionary Authority

The Plan has the discretionary authority to interpret the Agreement in order to make eligibility and benefit determinations. The Plan also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement. In no way shall this section limit any Member's rights as set forth in the Resolving Complaints and Grievances section or any rights permitted under law.

14.25 Value Added Services

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

[14.26 [Legal Action

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in

TN AR MS Group PPO_COC_10_CHL (9/2010)

[Approved]

[xx/xx/xx]

[Page 131 of 134]

accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.]

SECTION 15

UTILIZATION REVIEW POLICY AND PROCEDURES

15.1 Utilization Review Circumstances

Utilization review is performed under the following circumstances:

- Prospective or Pre-Service Review - Conducting utilization review for the purpose of Prior Authorization is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Prior Authorization.
- Concurrent Care Review - Review that occurs at the time care is rendered. When You are Hospitalized or Confined to a SNF, concurrent review is conducted on site or by telephone with the utilization review department at each facility.
- Retrospective or Post-Service Review - Retrospective or Post-Service review is utilization review that takes place for medical services that have not been Authorized by the Plan, after the services have been provided. For example, Emergency Room visits are reviewed after they occur.

Toll Free Telephone Number - The toll free telephone number of the utilization review department is listed in the Plan's Schedule of Important Telephone Numbers and Addresses. Voice messages recorded regarding Utilization Review will be returned within two (2) working days.

15.2 Timing Of Utilization Review Decisions

The time-frame for making utilization review decisions is as follows:

- Prospective or Pre-Service Review –
 1. Notification of a determination shall be within two (2) business days (twenty-four (24) hours for Urgent Care) of the receipt of the request and receipt of all information necessary to complete the review.
 2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
 3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.
- Concurrent Care Review –

1. Notification of a determination shall be within two (2) business days (twenty-four (24) hours for Urgent Care) of the receipt of the request and receipt of all information necessary to complete the review.
 2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
 3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.
- Retrospective or Post-Service Review –
 1. Notification of a determination shall be within two (2) business days of the receipt of the request and receipt of all information necessary to complete the review.
 2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
 3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.

15.3 Reconsideration

You have the right to request reconsideration of any adverse determination involving a Prospective or Pre-Service Review as well as any Concurrent Care Review determination. In the case of a Prospective or Concurrent Care Review determination, the attending Physician shall have the right to appeal that determination over the telephone on an expedited basis, if he/she believes that the determination warrants immediate Appeal.

A decision shall occur within forty-eight (48) hours of the date the reconsideration is filed and the receipt of all information necessary to complete the reconsideration.

15.4 Right To Appeal

If the reconsideration process does not resolve the difference of opinion, the Adverse Benefit Determination may be appealed by You or Your Provider on Your behalf through the standard appeal process. Please see the Complaint and Grievance Procedure Section for the time frames for such Appeals. Reconsideration is not a prerequisite to any Appeal.

**SCHEDULE OF IMPORTANT TELEPHONE
NUMBERS AND ADDRESSES**

<p>Coventry Health and Life Insurance Co. Member Services 5350 Poplar Avenue, Ste 390 Memphis, TN 38119 (866) 765-7747 (866) 765-7659 TDD</p>	<p>Coventry Health and Life Insurance Co. Medical Management 14955 Heathrow Forest Parkway Houston, TX 77032 (800) 292-4470</p>
<p>Coventry Health and Life Insurance Co. Physician/Ancillary/Facility Claims Department P.O. Box 7170 London, KY 40742 (866) 765-7747</p>	<p>Coventry Behavioral Health Line 5350 Poplar Avenue, Ste 390 Memphis, TN 38119 (877) 765-865-2566 (866) 765-7659 TDD</p>
<p>Coventry Health and Life Insurance Co. Member Appeals P.O. Box 7155 London, KY 40742 (866) 765-7747 (866) 765-7659 TDD</p>	<p>Contact the appropriate department based on the state your Plan is delivered in and governed by:</p> <p>[Consumer Insurance Services Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Davy Crockett Tower, 4th Floor Nashville, TN 37243-0574 (800) 342-8385]</p> <p>[Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904 (800) 852-5494 insurance.consumers@arkansas.gov]</p> <p>[Mississippi Department of Commerce and Insurance P.O. Box 79 Jacksonville, MS 39205-0079 (800) 562-2957 (601) 359-1077 Fax]</p>

Schedule of Benefits

This Schedule is part of Your Certificate of Coverage (COC) but does not replace it. Many words are defined elsewhere in the COC, and other limitations or exclusions may be listed in other sections of Your COC. Reading this Schedule by itself could give You an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your COC. [This is a Qualified High Deductible Health Plan (QHDHP). Please see Section 2.10 for additional information regarding Your benefits.] Coinsurance amounts are a percentage of the Plan’s Out-of-Network Rate (ONR)¹. Prior Authorization may be required for some services. Please refer to Your COC for further details or contact Member Services at the phone number listed in the “Schedule of Important Numbers and Addresses” section of Your COC or on the back of Your ID card.

Covered Services	Member Responsibility In-Network	Member Responsibility Out-of-Network
<p>Annual Deductible</p> <p>Total amount a Member is required to pay each calendar or Contract Year before he or she is eligible for certain Health Services. The Annual Deductible need only be met once per Member per calendar or Contract Year.</p> <p>[Pharmacy Services are included in the Deductible.]</p> <p>In some cases, In-Network Deductible will not apply.</p>	<p>Individual [\$0-\$15,000]</p> <p>Family [\$0-\$45,000]</p>	<p>Individual [\$0-\$45,000]</p> <p>Family [\$0-\$90,000]</p>
<p>Annual Out-of-Pocket Maximum</p> <p>[Copayments,] [Annual Deductible,] [and] [Coinsurance] apply to the Out-of-Pocket Maximum</p> <p>[Pharmacy Services are included in the Annual Out-of-Pocket Maximum.]</p>	<p>Individual [\$0-\$30,000]</p> <p>Family [\$0-\$75,000]</p>	<p>Individual [\$0-\$90,000]</p> <p>Family [\$0-\$150,000]</p>
<p>[Maximum Annual Benefit]</p>	<p>[Individual] [Unlimited]</p> <p>[Family] [Unlimited]</p>	<p>[Individual] [Unlimited]</p> <p>[Family] [Unlimited]</p>
<p>[Maximum Lifetime Benefit]</p>	<p>[Unlimited]</p>	<p>[Unlimited]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

<p>Physician Office - Preventive Care^[2]</p> <p>Services with a rating of "A" or "B" by the United States Preventive Services Task Force, Immunizations as recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and comprehensive guidelines supported by the Health Resources and Services Administration</p> <p>Services include routine health assessment, well-child care, child health supervision services, immunizations, hearing test, annual self-referred gynecological examination and pap smear. For a comprehensive list of the specific Preventive Care Services:</p> <p>www.healthcare.gov/center/regulations/prevention/recommendations.html</p>	<p>Covered in Full</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [4-Unlimited visits]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% of ONR Coinsurance per visit] [after Deductible]</p> <p>[Covered in Full]</p>
<p>Physician Office – Medical Services</p> <p>Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, injections, surgery, allergy tests and treatment.</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% Coinsurance per visit] [after Deductible]</p> <p>For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% Coinsurance per visit] [after Deductible]</p>	<p>For Primary Care Services [\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] For Specialty Care Services [\$0-\$250 Copay per visit] [or][then] [0-50% of ONR Coinsurance per visit] [after Deductible]</p>
<p>Chiropractic Office Visits</p> <p>Services include treatment that is Medically Necessary, clinically appropriate, and within the chiropractor’s scope of practice.</p> <p>[Visit limitation is an In-Network and Out-of-Network combined limit.]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]]</p>
<p>Emergency Room Services</p>	<p>[\$0-\$500 Copay per visit]</p>	<p>[\$0-\$500 Copay per visit]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

Coverage is provided for worldwide Emergency Health Services as defined in section [1.39] [1.40] of the COC.	[or] [then] [0-50% Coinsurance per visit] (waived if the patient is admitted) [after Deductible]	[or] [then] [0-50% of ONR Coinsurance per visit] (waived if the patient is admitted) [after Deductible]
Emergency Ambulance Services Coverage is provided for Emergencies as defined in Sections [1.39][1.41] and [6] of the COC.	[\$0-\$500 Copay per occurrence] [or] [then] [0-50% Coinsurance per occurrence] [after Deductible]	[\$0-\$500 Copay per occurrence] [or] [then] [0-50% of ONR Coinsurance per occurrence] [after Deductible]
Urgent Care Services Urgent Care Services at Alternate Facilities both in and out of the Service Area are Covered.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]
Maternity Care Office Visits Covered Services include pre-natal and post-natal care, examinations, tests and educational services.	[\$0-\$250 Copay first visit only] [or] [then] [0-50% Coinsurance first visit only] [after Deductible]	[\$0-\$250 Copay first visit only] [or] [then] [0-50% of ONR Coinsurance first visit only] [after Deductible]
Maternity Care, Inpatient Hospital Covered Services include all Physician services for mother and newborn(s), delivery, newborn nursery services, and Semi-private room.	[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible]	[\$0-\$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid.]
[Alcohol Conditions Office Visits Services include diagnosis, consultation and treatment in a Physician's office.]	[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[25-Unlimited] Visits] [per calendar/Contract Year]	[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[25-Unlimited] Visits] [per calendar/Contract Year]
[Alcohol Conditions Outpatient Services Coverage is provided for treatment of alcoholism in a partial or full day non-residential treatment program. Prior Authorization from the Plan's Mental Health and Substance Abuse Designee	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

<p>may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.]</p>		
<p>[Alcohol Conditions Inpatient Hospitalization Services Coverage is provided for Inpatient Days for treatment of alcoholism and Detoxification. Prior Authorization from the Plan’s Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify]</p>
<p>Mental Health Conditions and Chemical Dependency Services Office Visits Services include diagnosis, consultation and treatment in a Physician’s office. Prior Authorization from the Plan’s Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [25-Unlimited] [Visits] [per calendar/Contract Year]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [25-Unlimited] [Visits] [per calendar/Contract Year]</p>
<p>Mental Health Conditions and Chemical Dependency Services Inpatient Hospital Coverage is provided for Medically Necessary Hospital services, Semi-private room, nursing care, meals. Prior Authorization from the Plan’s Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible] [Limited to [20-Unlimited] Days] [per calendar/Contract Year]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar/Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid.] [Limited to [20-Unlimited] Days] [per calendar/Contract Year]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

<p>Mental Health Conditions and Chemical Dependency Outpatient Hospital Coverage is provided for partial or full day nonresidential treatment programs. Prior Authorization from the Plan’s Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[20-unlimited] Visits [per calendar/Contract Year]]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid] [[20-unlimited] Visits [per calendar/Contract Year]]</p>
<p>Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology, not performed in the Physician’s office. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>Outpatient Surgery Benefits are provided for Covered Services rendered at an outpatient Hospital and may include an overnight observation stay. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar/Contract Year] [after Deductible]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>[Outpatient Surgery Freestanding Facility Benefits are provided for Covered Services rendered at a Freestanding surgery center.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar /Contract Year] [after Deductible]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

		exceed \$2500 or 40% of the benefit paid]]
<p>TMJ [and CMD] Coverage for Phase I non-surgical treatment. Surgery under Phase II will be Covered as per the Outpatient Surgery or Inpatient Hospital Services (whichever is Medically Necessary) Sections. Refer also to Your COC.</p> <p>[Maximum benefit is an In-Network and Out-of-Network combined limit.]</p> <p>[Lifetime Maximum benefit is listed in the Temporomandibular Joint Disorder and Craniomandibular Disorder Rider]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [up to a maximum benefit of [\$500-unlimited] per calendar/Contract Year]</p>	<p>[\$0-\$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [up to a maximum benefit of [\$500-unlimited] per calendar/Contract Year]</p>
<p>High Technology Diagnostic Services, Tests, and Procedures Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar/Contract Year] [after Deductible]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>Infertility Services</p> <p>[Lifetime Maximum Benefit is limited to \$15,000 per Lifetime.]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar/Contract Year] [after Deductible]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>[Injectables] Includes Injectable medications, allergy and therapeutic injections and chemotherapy. There may be more than one Copayment/Coinsurance charged by the same Provider on the same day.</p>	<p>[\$0-\$500 Copay] [or] [then] [0-50% Coinsurance] per injection with the exception of immunizations [after Deductible]</p>	<p>[\$0-\$500 Copay] [or][then] [0-50% of ONR Coinsurance] per injection with the exception of immunizations [after Deductible]]</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

<p>Inpatient Hospital Services Coverage is provided for Medically Necessary Physician and surgeon services, Semi-private room, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>Transplant Services Services and supplies for certain transplants are Covered [when provided at a Designated Transplant Network Facility and by a Designated Transplant Network Physician]. Please see Your COC for further details.</p> <p>[Donor testing is limited to 4 potential donors]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible]</p> <p>[Covered only at a Designated Transplant Network Facility by a Designated Transplant Network Physician]</p>
<p>Skilled Nursing Facility Coverage is provided when approved by the Plan. Coverage is provided on a Semi-private basis.</p> <p>[Maximum benefit is an In-Network and Out-of-Network combined limit.]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/ Contract Year] [Limited to [30-150] days per] [calendar/Contract Year] [after Deductible]</p>	<p>[\$0-\$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [Limited to [30-150] days per] [calendar/Contract Year] [after Deductible] [\$0-\$1000 penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]</p>
<p>Home Health Care Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan.</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [20-unlimited visits]</p>	<p>[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure</p>

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

	combined services]	to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid] [20-unlimited visits combined services]
Hospice Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [20-unlimited visits combined services]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid] [20-unlimited visits combined services]
Durable Medical Equipment Coverage is provided when services are rendered by Providers and Authorized in advance by the Plan.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance of Covered expenses] [after Deductible]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]
Orthotics and Prosthetics Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan.	[\$0-\$500 Copay per visit] [or] [then] [0-50% Coinsurance of Covered expenses] [after Deductible]	[\$0-\$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid]
[Eyeglasses and Contacts Coverage is provided for the first pair of eyeglasses or corrective lenses following cataract surgery [Maximum benefit is an In-Network and Out-of-Network combined limit.]	100% of Covered eyewear up to [\$50-\$500]	[0-50% of ONR Coinsurance of Covered expenses] [after Deductible]]
[Hearing Aids Coverage is provided for hearing aids. [Maximum benefit is an In-Network and Out-of-Network combined limit.]	[\$0-\$500 Copay per hearing aid] [or] [then] [0-50% Coinsurance per hearing aid] [limited to a	[\$0-\$500 Copay per hearing aid] [or][then] [0-50% of ONR Coinsurance per hearing aid] [limited

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

	benefit maximum of \$0-\$5000] [after Deductible]	to a benefit maximum of \$0-\$5000] [after Deductible]]
<p>Physical, Occupational, and Speech Therapy</p> <p>Coverage is provided for Medically Necessary outpatient physical, occupational, and speech therapy when rendered by licensed Providers and Authorized in advance by the Plan.</p> <p>[Maximum benefit is an In-Network and Out-of-Network combined limit.]</p>	<p>[\$0-\$500 Copay per visit [or] [then] [0-50% Coinsurance per visit [after Deductible] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [20-unlimited visits combined Physical, Occupational, and Speech therapy]</p>	<p>[\$0-\$500 Copay per visit [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed \$2500 or 40% of the benefit paid] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [20-unlimited visits combined Physical, Occupational, and Speech therapy]</p>

¹See sections 1.80 and 2.7 of Your COC for further explanation.

[²Some Covered Services that You receive during a Preventative Service office visit may not qualify as Preventative Services under the Agreement and, consequently, will be subject to applicable Deductibles. In order to be exempt from applicable Deductibles, Preventative Services must qualify as Preventative Services under the Agreement and Section 223 of the Internal Revenue Code.]

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COPAYMENT, COINSURANCE AND DEDUCTIBLES.

**COVENTRY HEALTH AND LIFE INSURANCE COMPANY
SUPPLEMENTAL RIDER FOR DOMESTIC PARTNER BENEFITS**

This Rider is issued by Coventry Health and Life Insurance Company (“**CHL**”) and made a part of the Certificate of Coverage (“**COC**”) to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions and conditions of the COC apply to this Rider except to the extent such terms and conditions are explicitly superseded or modified by this Rider.

The benefits provided by this Rider become effective for Eligible Employees and their Dependents on the date that Your Group purchased this supplemental Rider (“Effective Date”) and expire when the Group’s Coverage under this Rider terminates.

ARTICLE 1 - DEFINITIONS

Domestic Partner - An unrelated adult of the same or opposite sex of the Subscriber with whom the Subscriber is living in a committed and exclusive long-term relationship, similar to marriage, and in which the partners are jointly responsible for one another’s welfare and financial obligations.

ARTICLE 2 - ELIGIBILITY

A Domestic Partner shall be Eligible for the same coverage as a Dependent spouse under the COC.

ARTICLE 3 - ENROLLMENT REQUIREMENTS

Individuals seeking enrollment as Domestic Partners must complete the Affidavit of Domestic Partnership. This form, included as Attachment A, sets forth the terms and conditions of the domestic partnership. The Affidavit of Dependent Status of Domestic Partner is included as Attachment B. The Domestic Partnership Statement of Termination, declaring termination of the domestic partnership, is included as Attachment C.

SERFF Tracking Number: FLHI-126789389 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 46993
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/25/2010
Comments:		
Attachment: AR Flesch Score COC Dom Partner.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/25/2010
Comments: Enrollment/Change Form 2-25 (form # CHAR 00001, approved 2/11/08) Enrollment/Change Form 26-50 (form # CHAR 00002, approved 2/11/08) Enrollment/Change Form 51-99(form # CHAR 00003, approved 2/11/08) Enrollment/Change Form 51+(form # CHAR 00004, approved 2/11/08) Application for Benefits Offerings (form # CHAR 00005, approved 2/11/08) Employer Risk Appraisal Questionnaire (form # CHAR0006 (4/09), approved 5/29/09)		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	10/25/2010
Comments:		
Attachment: PPACA Compliance Summary 09272010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	10/25/2010
Comments: Please note our benefit levels for PPO and NonPPO coinsurance will comply with Bulletin 9-85 and 9-85A. In regards to Transplant Services, we will cover Out-of-Network benefits for plans situated in Arkansas and our text is variable to allow for this service.		

SERFF Tracking Number: *FLHI-126789389* *State:* *Arkansas*
Filing Company: *Coventry Health and Life Insurance Co.* *State Tracking Number:* *46993*
Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *AR Schedule of Benefits, Domestic Partnership Rider and Certificate of Coverage PPACA*
Project Name/Number: /

Attachment:

Group PPO Statement of Variability.pdf

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

2751 Centerville Road, Suite 400
Wilmington, Delaware 19808-1627

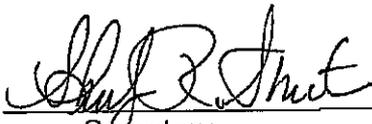
FLESCH READING EASE TEST

This is to certify that the form(s) listed below are in compliance with readability requirements pursuant to Arkansas Code Stat. 23-80-206 and have a readability score of forty (40) or higher.

The Flesch Test was applied to each form in its entirety, except that any of the following language may have been redacted: name and address of insurer, name or title of policy, table of contents, captions, subcaptions, policy language which was drafted to conform to any applicable law or regulation, any medical terminology or defined terms in the policy.

FORM NUMBER(S)

TN AR MS-DOMPART-08/2010 - Domestic Partner Rider
TN AR MS Group PPO_COC_10_CHL (9/2010) - Certificate of Coverage



Secretary

DATE: September 27, 2010

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

INDIVIDUAL HEALTH BENEFIT PLANS (Complete [SECTION A](#) only)

SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				<input type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes [◇] <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

Statement of Variability

We are filing the following documents in Tennessee, Arkansas and Mississippi.

Schedule of Benefits (PPO) - TNARMS SOB10_CHL (9/2010)

Certificate of Coverage (PPO) - TN AR MS Group PPO_COC_10_CHL (9/2010)

Supplemental Rider for Domestic Partner Benefits - TN AR MS-DOMPART-08/2010

We have created one Schedule of Benefits, Certificate of Coverage and Supplemental Rider for Domestic Partner Benefits to be used in all three states.

Items in the forms are bracketed. Certain bracketed variables contain a range of values. Only values within that range will be used. Other items that are bracketed will be either included or excluded. See the "Certificate of Coverage" section below for additional information.

Certificate of Coverage

In using one Certificate of Coverage, we have either (i) broken out certain benefits by where the plan is governed, (ii) bracketed text for certain state variations or (iii) have incorporated a benefit based on the state with the richest benefit requirement.

Certain benefits and sections within the Certificate of Coverage will include the phrase "**For Plans delivered in and governed by the laws of the State of...**" which will let the member know which benefit language will apply to them. Section 14.2 "Governed Law" will let the member know the situs state of their plan.

Below are items which have certain text bracketed within a benefit based on a state variation and will vary based on where the plan is situated.

1. Under Child Health Supervision Services on page 54 - for plans issued in Arkansas, the "Criteria and Coverage Provided" column would read as follows based on Arkansas law:

"Coverage is provided for the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards, including testing for lead poisoning for children under the age of six (6). Periodic reviews are Covered (up to 20 visits) from the date of birth through the age of eighteen years at the following intervals: birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, and yearly after age two years until age six (6) and every two years after age six (6) up to age eighteen (18).

Coverage is also provided for the treatment of autism spectrum disorders for Members under twelve (12) years of age. "

For plans issued in Mississippi or Tennessee, the "Criteria and Coverage Provided" column would read as:

"Coverage is provided for the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards, including testing for lead poisoning for children under the age of six (6). Periodic reviews are Covered from the date of birth through the age of twelve years at the following intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, and yearly after age two years until age sixteen (16).

Coverage is also provided for the treatment of autism spectrum disorders for Members under twelve (12) years of age. "

2. Under Newborn Care on page 72 - the following bracketed text will only be used when a plan is issued in the state of Arkansas:

[sickle cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.]

The following bracketed text will only be used when a plan is issued in the state of Mississippi or Tennessee:

[and such other common metabolic or genetic diseases that would result in mental retardation or physical dysfunction.]

3. Under Preventive, Diagnostic and Treatment Services on page 75 - the last paragraph is bracketed and will be included when the plan is a QHDHP.
4. Under Transplants on page 83, the bracketed text pertaining to the TennCare Program will only be included when a plan issued in the state of Tennessee. For Arkansas, we will remove the text "[Services received at a non-Designated Transplant Network Facility will not be Covered.]".
5. Section 14.26 "Legal Action" on page 130 will only be included when a plan is issued in the state of Mississippi.