

SERFF Tracking Number: CVKS-127719573 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Product Name: Individual Policy
Project Name/Number: /

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Individual Policy

SERFF Tr Num: CVKS-127719573 State: Arkansas

TOI: H16I Individual Health - Major Medical

SERFF Status: Closed-Approved-
Closed State Tr Num: 50033

Sub-TOI: H16I.005A Individual - Preferred
Provider (PPO)

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor,
Donna Lambert

Authors: Jennifer Simms, Lisa
Foos, Vanda Johnson

Disposition Date: 11/04/2011

Date Submitted: 10/14/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 01/01/2011

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: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 11/04/2011

State Status Changed: 11/04/2011

Deemer Date:

Created By: Jennifer Simms

Submitted By: Jennifer Simms

Corresponding Filing Tracking Number: Policy
& OOC

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

restating individual policy in hopes to increase user feasibility

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Company and Contact

Filing Contact Information

Jennifer Simms, Regulatory Compliance Analyst
 jesimms@cvty.com
 8320 Ward Parkway
 Kansas City, MO 64114
 866-795-3995 [Phone] 4539 [Ext]
 816-460-4695 [FAX]

Filing Company Information

Coventry Health and Life Insurance Company
 8320 Ward Parkway
 Kansas City, MO 64114
 (866) 795-3995 ext. 4539[Phone]
 CoCode: 81973
 Group Code: 1137
 Group Name: Coventry Health Care
 FEIN Number: 75-1296086
 State of Domicile: Delaware
 Company Type: LAH
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 2 forms @ \$50 each.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$100.00	10/14/2011	52812080
Coventry Health and Life Insurance Company	\$50.00	11/01/2011	53378855

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/04/2011	11/04/2011

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	10/31/2011	10/31/2011	Jennifer Simms	11/01/2011	11/01/2011
Pending Industry Response	Rosalind Minor	10/18/2011	10/18/2011	Jennifer Simms	10/26/2011	10/26/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Rate	Jennifer Simms	11/02/2011	11/02/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Rates	Note To Filer	Rosalind Minor	10/31/2011	10/31/2011

SERFF Tracking Number: CVKS-127719573 *State:* Arkansas
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(PPO)
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Project Name/Number: /

Disposition

Disposition Date: 11/04/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Not Reviewed

Comment:

The actuarial memorandum and rates were previously approved. They are attached to this submission as per my request for informational purposes only.

Rate data does NOT apply to filing.

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Product Name: Individual Policy
 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	Health - Actuarial Justification	Accepted for	No
		Informational Purposes	
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Coverletter 2011 10 13	Approved-Closed	Yes
Supporting Document	SOB and TMJ Rider	Approved-Closed	Yes
Supporting Document	Rate	Approved-Closed	No
Form (revised)	Individual Policy	Approved-Closed	Yes
Form	Individual Policy	Replaced	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Change Form	Approved-Closed	Yes

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(PPO)
Product Name: Individual Policy
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/31/2011
Submitted Date 10/31/2011

Respond By Date

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

With respect to newborn children on Page 23, are benefits provided as outlined under ACA 23-79-129 (a)(2)(B)?

Also, under Special Enrollment on Page 23, it is stated...."For Coverage to continue beyond the first (5) days, an application agreement to enroll the newborn must be received within ninety (90) days from the date of birth and subject to all eligibility requirements....". ACA 23-79-129 and our bulletin 3-75 requires that the insured provide notice within 90 days or the next premium due date which is greater. If you use an application as the notification and the insured provides notice within the time period, the newborn cannot be underwritten. Please advise if you are using the application as the notice and that the newborn is not being underwritten.

Objection 2

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

It is requested that you provide a copy of the schedule of benefits along with the statement of variability.

Objection 3

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

On Page 21, Exclusions, there is an exclusion for TMS and MPDS unless covered by an attached rider.

TMJ is a mandated offering as outlined under ACA 23-79-150. Do you have a rider that complies with the law? Also, does the approved application contain a statement as outlined under ACA 23-79-150(c)(2)?

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(PPO)
Product Name: Individual Policy
Project Name/Number: /

Objection 4

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

The policy must provide benefits for Gastric Pacemaker as outlined under ACA 23-99-419.

Objection 5

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

Under General Provisions on Page 40, there is language for Discretionary Authority. This language is not allowed under an individual major medical product.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: CVKS-127719573 State: Arkansas
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 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 11/01/2011
 Submitted Date 11/01/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Newborn's are not underwritten when enrolled timely. As I was about to load the previously filed and approved Change Form for documentation, I noticed that a 31-day requirement to enroll had inadvertently been left. Now attached under the Form Tab, is the change form used to enroll Newborns with the appropriate 90-day period referenced for your review and approval.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

With respect to newborn children on Page 23, are benefits provided as outlined under ACA 23-79-129 (a)(2)(B)?

Also, under Special Enrollment on Page 23, it is stated...."For Coverage to continue beyond the first (5) days, an application agreement to enroll the newborn must be received within ninety (90) days from the date of birth and subject to all eligibility requirements....". ACA 23-79-129 and our bulletin 3-75 requires that the insured provide notice within 90 days or the next premium due date which is greater. If you use an application as the notification and the insured provides notice within the time period, the newborn cannot be underwritten. Please advise if you are using the application as the notice and that the newborn is not being underwritten.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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SERFF Tracking Number: CVKS-127719573 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

	Number	Date	Specific Data	Score	Document
Change Form	CHL-AR-APP-008-11.11		Application/Enrollment Form	Initial	CHL-AR-APP-008-11.11.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Attached under the Supporting Documentation tab, please find Schedule of Benefits. Statement of Variability has been attached within the cover letter for this form. Previous statement of variability was provided within SERFF filing/approval of Schedule of Benefits.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

It is requested that you provide a copy of the schedule of benefits along with the statement of variability.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: SOB and TMJ Rider

Comment: Previously filed and approved under CVKS-126855093 and will be used with this filing.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: TMJ Rider was previously filed and approved and attached for your reference.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

SERFF Tracking Number: CVKS-127719573 State: Arkansas
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(PPO)
Product Name: Individual Policy
Project Name/Number: /

Comment:

On Page 21, Exclusions, there is an exclusion for TMS and MPDS unless covered by an attached rider.

TMJ is a mandated offering as outlined under ACA 23-79-150. Do you have a rider that complies with the law?
Also, does the approved application contain a statement as outlined under ACA 23-79-150(c)(2)?

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: SOB and TMJ Rider

Comment: Previously filed and approved under CVKS-126855093 and will be used with this filing.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: Coventry acknowledges the Gastric Pacemaker mandate and certifies compliance with ACA 23-99-419. This procedure is part of standard coverage offering prior to ACA 23-99-419, as such and with many other services is not required to be listed as it is not specifically excluded. Individuals requiring Gastric Pacemakers, when determined medical necessary, would be covered.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

The policy must provide benefits for Gastric Pacemaker as outlined under ACA 23-99-419.

Changed Items:

No Supporting Documents changed.

SERFF Tracking Number: CVKS-127719573 State: Arkansas
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 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: Discretionary Authority provision deleted, per your Objection. Please see revisions in attached form.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

Under General Provisions on Page 40, there is language for Discretionary Authority. This language is not allowed under an individual major medical product.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Policy	CHL-AR-POL-022-09.11		Policy/Contract/Fraternal Certificate	Initial			CHL-AR-POL-022-09.11.pdf
Previous Version							
Individual Policy	CHL-AR-POL-022-09.11		Policy/Contract/Fraternal Certificate	Initial			CHL-AR-POL-022-09.11.pdf

No Rate/Rule Schedule items changed.

Sincerely,

SERFF Tracking Number: CVKS-127719573 *State:* Arkansas
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Company Tracking Number:
TOI: H16I Individual Health - Major Medical *Sub-TOI:* H16I.005A Individual - Preferred Provider
(PPO)
Product Name: Individual Policy
Project Name/Number: /
Jennifer Simms, Lisa Foos, Vanda Johnson

SERFF Tracking Number: CVKS-127719573 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)
Product Name: Individual Policy
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/18/2011

Submitted Date 10/18/2011

Respond By Date

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

Before I review the policy, please advise if this policy is going to replace a previously approved policy. If so, what is the form number of the policy and when was it approved by our Department. Also, what rates will be used with this product?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)
Product Name: Individual Policy
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/26/2011
Submitted Date 10/26/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: This form will replace form previously filed and approved form CHL-AR-COC-001-10.10 under CVKS-126855093. The rate filing previously filed and approved is located under the same SERFF filing CVKS-126855093 and applies to this current form.

Related Objection 1

Applies To:

- Individual Policy, CHL-AR-POL-022-09.11 (Form)

Comment:

Before I review the policy, please advise if this policy is going to replace a previously approved policy. If so, what is the form number of the policy and when was it approved by our Department. Also, what rates will be used with this product?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Jennifer Simms, Lisa Foos, Vanda Johnson

SERFF Tracking Number: CVKS-127719573 *State:* Arkansas
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Company Tracking Number:
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(PPO)
Product Name: Individual Policy
Project Name/Number: /

Amendment Letter

Submitted Date: 11/02/2011

Comments:

Rates attached, previously filed and approved, per note.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Rate

Comment: Attached per Filer Note, for documentation.

2011 01 01 (Rev 2).pdf

SERFF Tracking Number: CVKS-127719573 *State:* Arkansas
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Company Tracking Number:
TOI: H16I Individual Health - Major Medical *Sub-TOI:* H16I.005A Individual - Preferred Provider
(PPO)
Product Name: Individual Policy
Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 10/31/2011 02:36 PM

Last Edited By:

Rosalind Minor

Submitted On:

11/04/2011 09:32 AM

Subject:

Rates

Comments:

You stated that the previously approved rates will be used with this submission.

For information purposes, please attach a copy of the rates to the rate/rule tab.

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 Product Name: Individual Policy
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/04/2011	CHL-AR-POL-022-09.11	Policy/Contract/Fraternal Certificate	Individual Policy	Initial			CHL-AR-POL-022-09.11.pdf
Approved-Closed 11/04/2011	CHL-AR-OOC-009-10.11	Outline of Coverage	Outline of Coverage	Initial			CHL-AR-OOC-009-10.11.pdf
Approved-Closed 11/04/2011	CHL-AR-APP-008-11.11	Application/Change Form Enrollment Form		Initial			CHL-AR-APP-008-11.11.pdf



PREFERRED PROVIDER ORGANIZATION (“PPO”)

*PPO products are underwritten by Coventry Health & Life Insurance company
and administered by Coventry Health Care of Kansas, Inc.*

Arkansas

Carefully check the application agreement and write to Coventry Health & Life Insurance Company at the address listed below, within ten (10) days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application agreement. This application agreement is part of the Policy and the Policy was issued on the basis that answers to all questions and the information shown on the application agreement are correct and complete. You may return this Policy within ten (10) days of its receipt for a full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

**THIS BENEFIT DOCUMENT AND ALL ATTACHED RIDERS
SHOULD BE READ IN THEIR ENTIRETY.**

You have the full freedom of choice in the selection of any duly licensed health care professional. This benefit document has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers you use. Please consult this benefit document, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

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General Provisions35

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Using Your Benefits2

Utilization Review32

Amount of Premium	The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.
Payment of Premium	<p>The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1; Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.</p> <p>All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. Payments should be sent to:</p> <p style="text-align: center;">Coventry Health & Life Insurance Company [P.O. Box 6512] [Carol Stream, IL 60197-6512]</p>
Grace Period	You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.
Changes in Premiums	The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder. We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based. We may also change the amount of Your Premiums, upon ten (10) days written notice, if the Premiums of Your entire age classification are changed.
Reinstatement	<p>If any renewal Premium is not paid within the time granted You for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan 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 Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified You in writing of its disapproval of such application.</p> <p>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 You and the Plan shall have the same rights hereunder 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 the Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.</p>

USING YOUR BENEFITS

Identification (ID) Card

Every individual receives an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. 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 cannot identify You as a participant of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343]; or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on Your ID card and in the Schedule of Important Numbers. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. 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 Policy.

How to Contact the Plan

Throughout this Policy, You will find that the Plan encourages You to contact Us 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 website 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 document.

Copayments, Coinsurance [and Deductibles]

You may be responsible for paying Copayments to Participating Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the Allowed Amount. [You may be responsible for the difference between the actual billed charges of a Non-Participating Provider and the Allowed Amounts.] [You must meet the applicable Deductible, as described in Your Schedule of Benefits, before benefits will be payable to Providers on Your behalf.] Specific Copayments[, Deductible] and Coinsurance amounts are listed in the Schedule of Benefits.

Prior Authorization

Prior Authorization is required for certain Covered Services as determined by the Plan. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Plan has the right to request and obtain whatever medical information it considers necessary to determine whether the service is Medically Necessary. You or the Participating Providers are required to obtain Prior Authorization for Covered Services. **You are responsible for verifying Prior Authorization has been obtained whenever You seek Covered Services from a Non-Participating Provider.** An up-to-date Prior Authorization List is available by contacting the Us at the telephone number listed on Your ID card or by visiting the Our website.

Any new, additional or extended services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All services identified in this document are subject to all of the terms, conditions, exclusions and limitations of the Plan.

It is important to note that under the terms of the Plan, Prior Authorization only determines Medical Necessity and appropriateness. All other terms of the Plan are

USING YOUR BENEFITS

then applied. If the Plan Prior Authorizes Covered Services, the Plan shall not subsequently retract the Authorization after the Covered Services have been received, or reduce payment unless: (1) Such Authorization is based on a material misrepresentation or omission about Your health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) Your Coverage under the Plan terminates before the health care services are provided.

To find out the amount of the penalty applied for failure to obtain Prior Authorization, please see [the Prior Authorization List or] the Schedule of Benefits.

If You are admitted for emergency care to a Non-Participating Facility, or in the case of an unexpected length of stay after a Prior Authorized admission to a Non-Participating Facility, the Plan may request that You be transferred to a Participating Facility for continuation of care when it is not medically contraindicated. If You refuse to be transferred to a Participating Facility, [the Plan will not cover any services beyond the proposed date of transfer][coverage will be provided] [at the Non-Participating level] [for services received after the proposed date of transfer].

Health Services Rendered by Participating Providers

You have access to the services of a Participating Provider of Your choice within the Provider network for Covered Services, subject to the terms, conditions, exclusions and limitations of the Policy. Participating Providers are contractually obligated to file all claims for You. Payment will be made directly to the Participating Provider for Covered Services.

It is Your responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. To verify the status of the Provider, please contact the Customer Service Department or check the Plan's website.

Coverage for Services by Non-Participating Providers

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You must submit a Claim form to the Plan. It is Your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of Your claim. 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. A claim will not be denied based upon the Your failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan. [No claim will be paid if not received by the Plan within one (1) year] [and ninety (90) days] [after services are received.]

[Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network Rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary Providers and other Providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network Rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You are required to make. However, if the amount You are charged is in excess of the Out-of-Network Rate

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for a particular Covered Service, You will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.]

[Non-Participating Physician and Other Health Care Professional Fees

The Out-of-Network Rate is equivalent to 100% of the national average Medicare rate, based on the previous year's Resource Based Relative Value Scale (RBRVS) fee schedule for Physician and other health care professional services, as such services are defined in the American Medical Association's Current Procedural Terminology (CPT) manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the previous year, the rate will be calculated using the assigned Relative Value Units (RVU) and the previous year's Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the [Medispan] [Average Wholesale Price (AWP)] or other nationally recognized source as determined by the Plan. Payment for anesthesia services will be 200% of the previous year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment (DME), prosthetics, orthotics and supplies (DMEPOS) will be at the previous year's DMEPOS ceiling limit. Payment for Laboratory services will be at the previous year's Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.]

[Non-Participating Facility Fees

The Out-of-Network Rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group (DRG) rates. Payment for outpatient services will be based on Ambulatory Payment Classification (APC) rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center (ASC) group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one Provider to the next, so please make sure You are aware of the billed charge for services You want to receive from Non-Participating Providers.]

Second Opinion Policy

You may seek a second medical opinion or consultation from the Plan's Participating Providers. In the event the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, the Plan will arrange for a referral to a Provider with the necessary expertise.

Participating Provider Terminations

The Plan or a Participating Provider may end the relationship with the other party after having supplied notice under applicable law; therefore the Plan does not promise that any specific Participating Provider will be available to render services to You. [If a Participating Provider no longer participates with the Plan, the Plan will provide immediate notice to You and assist You in selecting another Participating Provider.] The Plan will provide You continuation of care up to ninety (90) days by a Provider who is terminated

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from the network in those cases where such continuation of care is Medically Necessary and in accordance with the dictates of medical prudence and where You have special circumstances such as a disability, a life-threatening condition or is in the third trimester of pregnancy. You will not be liable to the Provider for any amounts owed for medical care other than the applicable Copayments, Coinsurance and/or Deductible as specified in the Schedule of Benefits.

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 Policy, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against You or a person, other than the Plan or intermediary, acting on Your behalf for services provided pursuant to this Policy. This Policy shall not prohibit the Provider from collecting [Coinsurance, Deductibles or] Copayments, as specifically provided in this document, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision 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 provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing You Coverage.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Policy. 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 Policy. The Plan shall have the right, subject to Your rights in this document, to interpret the benefits of this document and attached Riders, and other terms, conditions, limitations and exclusions set out in the Policy in making factual determinations related to the Policy, its benefits, and You; 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. Any termination of the Policy must be in accordance with the Termination of Coverage Section of this document. 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.

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The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Authorized, if required, (3) not expressly excluded in the list of Exclusions section, and (4) incurred while eligible for Coverage under the Plan. It is Your responsibility to verify whether a Covered Service requires Prior Authorization and should always reference the Authorization Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already obtained the Authorization. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service. Please note that the Covered Services are subject to all applicable provisions within this document, and any attached Schedule of Benefits, Riders, Amendments, or Endorsements.

Allergy

Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Exclusions:

- Sublingual drops.
- Non-Physician services and expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

Ambulance (air and ground)

For Emergency use, when transport by other means is not medically safe, and for non-Emergency transportation for the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care;
- To a more cost effective acute care Facility; or

When transportation is needed to a long term acute care or inpatient rehabilitation facility.

Exclusion:

Non-Emergency and non-medically appropriate ambulance services, regardless of who requested the services, including transport due to the absence of other transportation.

Blood and Blood Products Processing

Coverage is provided for administration, storage, and processing of blood and blood products in connection with Covered services.

Exclusions:

- Expenses related to personal blood storage, unless associated with a scheduled surgery.
- Fetal cord blood harvesting and storage.
- The cost of whole blood and blood products replacement to a blood bank.

Chemotherapy

Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.

Clinical Trials

Expenses associated with professional services, diagnostic laboratory and radiology tests, inpatient care, and administration of treatment and evaluation during the course of the treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever You receive medical care associated with an approved clinical trial, and which would be covered if such items and services were provided other than in connection with an approved clinical trial.

Exclusions:

- The costs of the Investigational drugs or devices themselves, or the costs of any

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non-medical services that might be required for You to receive the treatment or intervention.

- Transportation and/or lodging costs incurred while receiving such treatment.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in Your clinical management.
- Health care services customarily provided by the research sponsors of a trial free of charge for any member in the trial.
- Experimental or Investigational treatment not related to a Clinical Trial as defined above.

Compression Sleeves and Stockings

Coverage is provided for [two (2) pair of] compression sleeves and [two (2) pair of] compression stockings per Benefit Period.

Dental/Oral Surgery Services

Benefits for oral surgical procedures of the jaw or gums will be covered for:

- Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of symptomatic exostoses (bony growths) of the jaw and hard palate;
- Treatment of fractures and dislocations of the jaw and facial bones;
- Intraoral x-rays in connection with covered oral surgery; and
- General anesthetic for covered oral surgery.

Coverage is provided for diseases of the mouth, jaw and teeth related to radiation treatment, unless the condition is due to dental disease or of dental origin.

Limitations:

- Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:
 - The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and
 - The patient is:
 - A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
 - A person with a diagnosed serious mental or physical condition; or
 - A person with a significant behavioral problem as determined by Your physician.
 - If a person is Covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.
- Services relating to the acute trauma of sound, natural teeth caused directly by an accidental injury (not from biting or chewing) within a [six (6), twelve (12)] month consecutive period from the date of injury up to a maximum of \$1,000 of Allowed Amount(s). This benefit maximum does not apply to individuals under eighteen (18) years of age. A treatment plan must be submitted [within sixty (60) days of the injury] and approved by the Plan.

Exclusions:

- Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint).
- Dental x-rays, supplies and appliances including occlusal splints.
- Orthodontia and related services.

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- Oral surgery 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.
- Treatment of teeth or structures directly supporting the teeth, whether the services are considered to be medical or dental in nature except as specified above.

Dermatological Services

Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis

Coverage is provided 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 Services

Coverage includes Plan approved diabetic education classes, including self-management training used in connection with the treatment of diabetes; foot care, including medical or surgical treatment of onychomycosis (nail fungus); an annual diabetic retinal eye examination; and [one (1) pair of] orthopedic shoes and [two (2) pair] associated shoe inserts [per Benefit Period] for those individuals with demonstrated peripheral neuropathy.

Limitation:

Diabetic equipment and supplies, including disposable insulin syringes, glucose meters, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under the medical benefit.

Dietician Counseling

Coverage [for up to four (4) visits per Benefit Period] is provided when rendered by a registered dietician.

Disposable Medical Supplies

Specific disposable medical supplies are covered when prescribed by Your Physician. Covered disposable supplies are limited to:

- Inhaler supplies (aero chamber masks, spacers and peak flow meters)
- Ostomy supplies (appliance pouches, skin care agents, support belts);
- Open wound supplies (gauze pads, wound packing strips, ABD pads);
- Supplies used in conjunction with covered Durable Medical Equipment (except for diabetic supplies);
- Tracheostomy supplies;
- Urinary supplies limited to catheters, bags and related supplies; and
- Venous access catheter supplies (alcohol pads, benzoin, OP site).

Durable Medical Equipment (DME)

DME is medical equipment 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 DME will be considered DME.

Coverage is provided 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.

Limitations:

- Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All

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maintenance and repairs that result from misuse are Your responsibility.

- Benefits are provided for one wheelchair or scooter and for repairs of that unit.

Exclusions:

- Electronically controlled heating and cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff);
- Home traction units;
- Preventive or routine maintenance due to normal wear and tear or negligence of items You own;
- Replacement for changes due to obesity; and
- Personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as a Covered Service.

Emergency Services

Coverage will be provided for Emergency Services if the symptoms You present and records by the attending Physician indicate that an Emergency Medical Condition exists; or for Emergency Services necessary to provide You with a medical examination and stabilizing treatment, regardless whether Prior Authorization was obtained to provide those services. Services provided by a Hospital emergency department for non-Emergency Medical Conditions are not covered.

[In situations where You require Emergency Services and have no control over when or where such services are rendered, You will not be responsible for the difference between the Provider's billed charges and Allowed Amount(s).]

Eye Glasses and Corrective Lenses

Coverage will be provided for the first pair of [eyeglasses or] corrective lenses following cataract or cornea transplant surgery [up to a maximum of \$150] or one (1) pair of contact lenses; or one (1) pair of sclera shells intended for use as corneal bandages or for medically-diagnosed eye diseases approved by Our Medical Director. [Benefits are limited to the amount available for a basic (standard) frame which meet the minimum specifications for the corrective lens(es), the cost of basic frames shall not exceed {\$100}.]

Family Planning

Covered Services are limited to:

- Office visits, medical evaluation, and counseling;
- Testing required to establish the etiology of male infertility, which is limited to sperm counts and/or semen analysis; scrotal ultrasound; prostate ultrasound, biopsy, and cystoscopy;
- Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal). Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider]; and
- [Sterilization procedures (vasectomy or tubal ligation).]

Exclusions:

- Fee associated with donors;
- Collection or storage of sperm;
- Those services related to conception through artificial means including, but not limited to, artificial insemination (IUI), in-vitro fertilization (IVF), gamete intrafallopian

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transfer (GIFT), zygote intrafallopian transfer (ZIFT) and similar procedures;

- Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and other testing, including those provided in any Physician's office setting;
- Embryo transplants;
- Reversal of voluntarily induced sterilization;
- Expenses of surrogate motherhood;
- Selective reduction;
- Any experimental procedure;
- Office visits, laboratory, x-ray and other testing associated with any Non-Covered Service;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal)]; and
- [Sterilization procedures (vasectomy or tubal ligation)]

[For maternity care coverage, reference the Maternity Care section of this document and Schedule of Benefits.]

Foot Care

Coverage for routine foot care provided by a Physician, including the paring and removing of corns and calluses or trimming of nails, will only be provided for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.

Exclusions:

- Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain.
- Medical or surgical treatment of onychomycosis (nail fungus) except persons with circulatory impairment or as described in the Diabetic Services section.

Genetic Studies

Coverage is provided for genetic counseling and tests only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Exclusions:

- Genetic testing when performed primarily for screening purposes.
- Genetic testing when performed primarily for purposes of embryonic pre-selection.

Hearing Screenings

Coverage is provided for a hearing screening to determine hearing loss.

Exclusion:

Services and associated expenses for the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests.

Home Health Care Services

Home health services will be provided as indicated in the Schedule of Benefits if You require skilled care and are homebound due to a disabling condition, are unable to receive medical care on an ambulatory outpatient basis, and do not require confinement in a Hospital or other Participating Facility. In order to receive the Network level of benefits, Home health services must be provided by an accredited Participating home health agency. Home health services include:

- Periodic and intermittent diagnostic and therapeutic services which can only be performed by professional nurses and other Participating Health Professionals if the services are ordered by a Physician; and

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- Consumable medical supplies and DME administered or used by such persons in the course of services rendered during such visits.

Limitations:

- Physical, occupational and speech therapy are subject to the benefit limitations and Copayments as described in the Rehabilitation Services section of this document and the Schedule of Benefits.
- Intravenous and injectable medications are subject to the benefits as described in the Therapeutic Injections and IV Infusions section of this document and the Schedule of Benefits.
- Home services to help meet personal, family, or domestic needs, including but not limited to eating, bathing, grooming, toileting, dressing, transferring or other custodial or self-care activities and private duty nursing, whether or not required by a Physician. This exclusion does not apply to wheelchairs, walkers, canes and crutches.

Hospice

Coverage is provided for hospice care rendered by a Provider for treatment of the terminally ill when ordered by a Physician. 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, including the services of a skilled nurse, physical or occupational therapist, home health aide, social worker, or chaplain; and guidance and assistance during the illness for the purpose of preparing You and Your family for a terminal illness.

Inpatient Hospital Care

Inpatient Hospital and Facility services will be covered for evaluation or treatment of conditions that cannot be adequately treated on an outpatient basis. Coverage includes Semi-private accommodations and associated professional and ancillary services. Certain services rendered during a Your confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits.

Exclusion:

Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable.

Mental Health and Substance Abuse

Covered benefits under this section are those specified in the most current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) or the Plan's utilization policies when more generous. Benefits under this section are only covered if such treatment is rendered by a licensed Provider who has the legal authority to diagnose and treat mental illness or substance abuse. [In order to receive the Network level of benefits, You should visit Your family Physician or a Participating Provider for outpatient treatment.] [You may also visit a Non-Participating Provider and receive the Non-Network level of benefits.]

Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, is subject to the applicable Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits. Outpatient treatment, including treatment through partial or full-Day Program Services, is subject to the applicable Deductible, Copayment and/or Coinsurance for services provided by Specialty Physicians as listed in the Schedule of Benefits. Medical services in conjunction with Mental Health or Substance Abuse treatment are subject to the applicable benefit defined on the Schedule of Benefits.

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Exclusion:

Mental illness and/or chemical dependency services for the following: 1) services utilizing methadone treatment as maintenance, LAAM (1-Alpha-Acetyl-Methadol), cyclazocine, or their equivalent; except where methadone or its equivalent is used as medically prescribed treatment in a federally approved detoxification program for drug abuse; and 2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

Orthotic Appliances

Orthotic appliances correct or support a defect of a body form or function. Coverage is provided for the purchase of orthotic appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for orthotic appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if You have diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.

Exclusions:

- The replacement costs for any otherwise Covered appliance for changes due to obesity;
- Routine maintenance due to normal wear and tear or negligence of items You own;
- Foot or shoe inserts, arch pads, or insoles whether custom-made or prefabricated;
- Cranial (head) remodeling bands or any such service or supply for the treatment of positional non-synostotic plagiocephaly and other protective head gear.

Outpatient and Physician Office Services

Coverage will be provided for those services requested or directed by the Plan or a Physician to be provided on an outpatient basis, including:

- Diagnostic and/or treatment services.
- Lab services.
- Diagnostic and therapeutic radiology services.
- Health evaluations.
- Administered drugs, medications, biologicals, and fluids which have been approved by the FDA, have a National Drug Code, and are administered under the supervision of a Physician.
- Services which can be appropriately provided on an outpatient basis such as certain surgical procedures, which can include anesthesia, recovery room services, ambulatory surgical centers and Hospital outpatient surgical centers.
- Physician services, including office visits, Hospital visits, consultations, and interpretation of tests.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.
- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Origination site fees and technical component fees associated with telehealth.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food

Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.

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Limitation:

Enteral pumps and supplies will be covered only when the above criteria are met.

Exclusion:

The cost of outpatient Enteral tube feedings or formula and supplies are not covered except when used for PKU or any other amino and organic acid inherited disease, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition.

Preventive Services

If received from a Participating Provider, Coverage for the following services will be provided at in a manner consistent with Section 2713 of Federal H.R. 3590. Coverage for these services will be provided once annually, unless otherwise specified below:

- Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention (ACIP-CDC);
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings for women (including pap smears, breast cancer screening, mammography screenings, and osteoporosis screenings) not described in the first bullet.

A complete list of the covered preventive services, including any age limitations, is available on Our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Services number on Your ID card.

Please note:

- A preventive care service is designed to prevent or detect an illness, disease, or condition before the occurrence of the condition. This can include office visits, patient education, immunizations, and diagnostic testing. Preventive care services are performed before a disease is diagnosed and in the absence of symptoms. Services that are related to or in follow-up of an established illness, disease, condition and/or for a symptom are not part of a preventive care service.
- If a covered preventive service is provided during an office visit, it must either be billed separately from the office visit or be the primary purpose of the office visit in order to be covered under this benefit. If the preventive service is not billed separately and the primary purpose of the visit is not to provide the preventive service, then the applicable Copayments, Coinsurance and/or Deductible will apply to the office visit.

[In order to receive the Network level of benefits, You should visit Your family Physician or a Participating OB/GYN specialist for the annual well-woman exam or may visit a Participating urologist for the annual well-man exam. You may also visit another provider and receive the Non-Network level of benefits.]

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing,

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and court-ordered forensic or custodial evaluations.

- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Costs associated with immunizations for travel.

Prosthetic Devices

Prosthetic devices aid body functioning or replace a limb or body part and can be either internally or externally placed. Coverage is provided for the purchase of prosthetic devices following the onset or initial diagnosis of the condition for which the device is required. For prosthetic device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for prosthetic devices, including but not limited to, purchase of artificial limbs, bone anchored hearing aids, breasts, cochlear implants, 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. Coverage is provided for external prosthetic devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Coverage will be provided for replacement of prosthetic devices, which become non-functional and non-repairable due to: (1) A change in Your physiological condition; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a Dependent child requiring replacement.

Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.

Exclusions:

- Those repairs or replacement costs for any otherwise Covered device, including replacement for changes due to obesity.
- Routine maintenance due to normal wear and tear or negligence of items You own.
- Electronic or computerized prosthetic limbs.
- Eyeglasses and contact lenses, except as described as a Covered Service.
- Hearing aids, except as above; digital and programmable hearing devices; hair pieces, prosthesis and styling; dental plates, bridges, braces, or any dental prostheses.

Reconstructive Surgery

Reconstructive procedures are those services that are performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Procedures and services which are related to psychological consequences or socially avoidant behavior as a result of injury, illness or congenital or developmental anomaly do not classify surgery or other procedures as a reconstructive procedure.

Coverage is provided for reconstructive treatment or surgery only under the following circumstances:

- Correction or repair of an accidental injury even if a cosmetic effect occurs.
- Correction or repair of a body part to improve/restore impairments of bodily function resulting from disease, trauma, or previous therapeutic processes.
- Correction or repair of congenital abnormalities and hereditary complications or conditions are limited to:

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- Improving/restoring impairments of bodily function such as cleft lip or palate;
- Birthmarks on head or neck;
- Webbed fingers or toes; and
- Supernumerary digits or toes.
- Removal of leaking breast implants, not including implant replacement.
- Services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service and will be provided in a manner determined in consultation with You and the treating Physician including:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses and physical complications from all stages of the mastectomy, including lymphedema; and
 - Two (2) bras per Benefit Period will also be covered following the mastectomy

Exclusions:

- Elective or voluntary enhancement procedures, services, or medications for sexual performance, athletic performance, cosmetic purposes, anti-aging, or mental performance including, but not limited to: Botox, Restylane, growth hormone, testosterone, hair removal or hair transplant.
- Cosmetic therapies or surgical procedures primarily to restore or alter the appearance including, but not limited to: surgical excision or reformation of any sagging skin on any part of the body such as eyelids, face, neck, abdomen, arms, legs or buttocks; alabrasion; chemosurgery; laser surgery or other skin abrasion procedures related to removal of scars, tattoos, or actinic/acne changes.
- Services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body such as breasts, face, lips, jaw, chin, nose, ears or genitals (i.e. labia reduction).
- Treatment of gynecomastia.

Rehabilitation Services and Supplies

Rehabilitative services are designed to restore normal physical functions following injuries, surgeries, or acute medical conditions and are Covered when they are expected to resulting significant improvement in the patient's condition.

Services include physical, occupational, speech therapies, spinal manipulations, and cardiac and pulmonary rehabilitation. Authorization or referral may be required, please review the Prior Authorization list at the end of this document.

Spinal manipulation services are covered for the manual treatment used to influence joint and neurophysiological function.

Limitation:

Rehabilitation services are covered only if they are expected to result in significant improvement in Your condition. The Plan will determine whether significant improvement has, or is likely to occur based on the medical information received from Your Physician.

Exclusions:

- Therapy in which the goal is maintenance, rather than significant improvement.
- Convalescent or custodial care.

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- Vocational rehabilitation including, but not limited to, employment counseling and training.
- Cognitive therapy including, but not limited to: behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and/or mental retardation testing and treatment.
- Developmental therapy, unless a congenital condition is the underlying cause for the delay.
- Athletic evaluation and training.
- Services that federal or state laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).
- Speech therapy or voice training when prescribed for stuttering or hoarseness.
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column.

Therapeutic Injections and IV Infusions

Therapeutic injections and IV infusions are those prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the individual. Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.

Limitation:

Growth hormone therapy is only covered for those individuals under 18 years of age who meet the criteria for Coverage and who have been appropriately diagnosed with a growth hormone deficiency or pituitary disorder according to clinical guidelines used by the Plan.

Exclusions:

- Any drug, medicine or medication prescribed in doses exceeding the manufacturer-recommended maximum dose documented in the package insert that is approved by the FDA. This exclusion shall not apply to a drug, medicine or medication dose that is referenced in one of the standard reference compendia or in generally accepted peer-reviewed medical literature.
- Self-Injectable Prescription Drugs are drugs that are commonly and customarily administered by the individual according to clinical guidelines used by the Plan. Any Self-Injectable medication that is covered by a pharmacy Rider is excluded from the medical benefit.

Transplants

Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Designated Transplant Network Facility and You are the recipient.

[Donor screening tests are Covered when performed at a Designated Transplant Network Facility.

If not Covered by any other source, the cost of any care, including complications up to 90 days, arising from an organ donation by a non-participant when You are the recipient will be Covered for the duration of Your Policy when approved by the Plan.]

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in

COVERED SERVICES

autologous bone marrow transplants or stem cell transplants.

[If You reside more than {one hundred-fifty (150)} miles from the transplant facility, reimbursement for travel will be Covered.] [Travel expenses may include the lodging for You and a companion.] Lodging and meal costs incurred by You and a companion [is Covered in accordance with the Plan's utilization policy and procedure.][for a period beginning twenty-four (24) hours prior to admission for the transplant procedure and forty-eight (48) hours after Your discharge are also covered. Lodging and meal costs are subject to a \$125 per day limitation. Transportation, lodging and meal costs shall not exceed a maximum benefit of {\$2,000} per transplant.]

Exclusions:

- Any associated expenses, including complications, arising from an organ donation when You are the donor [and the recipient is not Covered under the Plan].
- Any associated expenses involving temporary or permanent mechanical or animal organs.
- Reimbursement for organ harvesting.

Urgent Care Services

A condition that requires urgent care is an unexpected illness or injury that is not life-threatening but requires prompt medical attention. Examples of urgent care conditions include sprains, lacerations and severe abdominal pain.

Vision Services

Coverage is provided for eye examination including medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.

Exclusions:

- Corrective contact lens fitting.
- Surgical treatment for the correction of a refractive error, including but not limited to: radial keratotomy, LASIK, or refractive lensectomy with intraocular lens implant.
- Other vision care services, including but not limited to: visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
- [Vision hardware (i.e. frames) unless covered under a Vision Rider.]

EXCLUSIONS

[Pre-Existing Conditions Limitation]

[Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date.

Pre-Existing Condition Exclusions shall not apply to any individual under the age of 19.]

The following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy.
- Any service or supply that is not Medically Necessary.
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service and subsequent complications which may occur.
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational.
- Court-ordered services including forensic or custodial evaluations; evaluations and diagnostic tests ordered or requested in connection with criminal or legal actions; damages in any kind of personal injury action, divorce, child custody, paternity, severance of parental rights, or child visitation proceedings; or services that are a condition of probation, parole or diversion agreements.
- Those services otherwise Covered under the Policy related to a specific condition when You have refused to comply with, or have terminated the scheduled service or treatment against the advice of a Provider or the Mental Health/Substance Abuse Designee.
- Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates.
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as You, or rendered by a person who is a member of Your family, including spouse, brother, sister, parent, stepparent, child or step-child.
- Any portion of a Claim that the Plan determines to be incorrectly or inappropriately billed by a Physician, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

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

Abortion

Services related to elective abortions unless covered under an attached Rider. An elective abortion is a termination of pregnancy for any reason other than a spontaneous abortion (miscarriage) or to prevent the death of the individual upon whom the abortion is being performed.

Alternative Therapies

All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupuncture, acupressure, hydro-massage, hypnotherapy, hypnosis, massage therapy, Vax-D therapy, reflexology, cranio-sacral therapy, and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.

EXCLUSIONS

Apparel	Items of wearing apparel including, but not limited to TENS unit sleeves, except as specified in the Covered Services section.
Augmentative Communication Devices	Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled individuals.
Autopsy	Those services and associated expenses related to the performance of autopsies, unless requested by the Plan, to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan.
[Biofeedback	Any expenses related to biofeedback.]
Chelation Therapy	Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
Counseling	Expenses related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
Custodial Care	Domiciliary care, convalescent care, residential care, respite care or rest care. This includes care that assists You 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 whether or not required by a Physician.
Duplicate Benefits	Benefits of this document will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This document will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services.
Eligible Expenses	Any otherwise eligible expenses that exceed the maximum allowance or benefit limit.
Food	Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for in the Covered Services Section.
Foreign travel	Care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services.
Fraud	Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or intentional fraud.
Halfway House	Services rendered or billed by a school or halfway house.
Hair analysis	Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
Health Club Membership	Any costs of enrollment in a health, athletic or similar club.

EXCLUSIONS

Household Equipment and Fixtures	Purchase or rental of household equipment including, but not limited to: fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hot tubs, hypo-allergenic pillows, pools, power assist chairs, mattresses or waterbeds, car seats, strollers, shower chairs, commodes, breast pumps, bedwetting alarms, prenatal cradles, electronic communication devices, braces and supports needed for employment, and modifications to Your home or vehicle.
Illegal Acts	Injuries incurred while You are in the commission or attempted commission of a felony, except when the injury is the result of You being a victim of domestic violence.
Immunizations	Those immunizations for travel, employment or education unless otherwise Covered under the Covered Services Section.
Maternity Services	Expenses incurred for any condition of or related to pregnancy, including childbirth, routine pregnancy visits, nursery care charges, and delivery whether by vaginal or Cesarean birth, or selective reduction. Complications due to or developed during pregnancy are Covered like any other illness.
Medical-Legal	Services rendered primarily for the purpose of medical-legal reasons including, but not limited to, a Provider/patient contract to determine and monitor compliance with prescribed drug treatment, or for the purpose of Provider malpractice protection, that lack medical necessity as defined by this document. This does not include monitoring for therapeutic medication levels, which are deemed Medically Necessary.
Military Health Services	Those services for treatment of military service-related disabilities when You are legally entitled to other Coverage and for which facilities are reasonably available to You; or those services for any otherwise eligible individual or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act.
Miscellaneous Service Charges	Miscellaneous service charges including, but not limited to, consultations performed through use of telephone, fax, or email communication; case management team conferences; consultations with family members; charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service); or any late payment charge.
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.
Non-Medical Ancillary Services	Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, educational testing, training, or therapy, unless approved by the Plan as part of treatment for traumatic head injury or stroke, or as specified in the Covered Services section.

EXCLUSIONS

Non-Prescription Drugs and Medications	Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional Pharmacy Rider.
Nutritional-Based Therapy	Nutritional-based therapies except for treatment of 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 regardless of whether it is the sole source of nutrition except as provided for under PKU or any other Amino and Organic Acid Inherited Disease Food/Formula.
Nutritional Supplements	Vitamins, minerals, nutritional supplements, medical foods, breast milk and formulas, or special diet foods whether or not required by a Physician except as required to be covered by law.
Obesity Services	Those 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, jejuna bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.
Over-the-Counter Supplies	ACE wraps, batteries, elastic supports, finger splints, orthotics, and braces; also over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, therabands, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider.
Pain Management	Costs associated with commercial pain management programs.
Personal Comfort and Convenience	Services or items for the Provider's or Your convenience including items or services such as home laboratory testing, television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Prescription Drugs and Medications	Prescription and non-prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider to the Policy.
Private Duty Nursing	Private duty nursing services, whether or not required by a Physician; nursing care on a full-time basis in Your home; or home health aides.
Rebating	Any service(s) rendered where You receive monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).
Replacement Items	Costs associated with the replacement of items that are damaged, lost, or stolen.

EXCLUSIONS

Sex Transformation Services	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.
Sexual Dysfunction	Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasm.
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 including braces, supports and orthotics.
TMJ and MPDS	Services related to the diagnosis and treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) unless covered by an attached Rider.
Third Party Liability	Services for which a third party has liability (by whatever terminology used-including such benefits mandated by law).
[Tobacco Cessation	Those services and supplies for tobacco cessation programs and treatment of nicotine addiction.]
Travel or Transportation Expenses	Transportation, food, and lodging expenses even though prescribed by a Participating Provider, except as specified in the Covered Services Section.
War or act of war	Services received as a result of war or any act of war when You are outside of the continental United States, whether declared or undeclared or caused during service in the armed forces of any country.
Workers compensation	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 program.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility

Medical Underwriting

Eligibility for Coverage under this Policy is based on health-related factors, excluding genetic testing. An evaluation of the applicant's medical history will determine acceptance and final Premium for this Coverage.

- In order to determine acceptance the Plan will review the Medical Questionnaire information from the Enrollment Form.
- If minor clarification is needed the Plan will send an additional questionnaire and ask You to complete the form.
- If more detailed information is needed additional medical information may be requested from the Provider listed on the Enrollment Form Medical Questionnaire or additional information provided by You.
- If we have not received the information requested within thirty (30) days, the application will be deemed denied.

Policyholder

To be eligible as a Policyholder, You must:

- Live [or work] in the Service Area during the entire Year unless on temporary work assignment of six (6) months or less;
- Pay required premiums when due; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

Dependents

To be eligible to be enrolled under this Policy as a Dependent, an individual must:

- Be the lawful spouse of the Policyholder or be a child of the Policyholder or the Policyholder's spouse including:
 - Children up to their twenty-sixth (26) birthday who are either the birth children of the Policyholder or the Policyholder's spouse or legally adopted by or placed for adoption with the Policyholder or Policyholder's spouse;
 - Children up to their twenty-sixth (26) birthday for whom the Policyholder or the Policyholder's spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
 - Children up to their twenty-sixth (26) birthday for whom the Policyholder or the Policyholder's spouse is the court-appointed legal guardian;
 - Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Policy Holder or the Policy Holder's Spouse 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 Insured upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

A spouse must live in the Plan's Service Area at least [six (6), nine (9)] months out of the year. [Notwithstanding the above, a common law spouse qualifies as a spouse under this Policy only if his or her spousal status is affirmed by a court of competent jurisdiction.]

Enrollment

Persons Not Eligible to Enroll

- A person who fails to meet the eligibility requirements specified in this Policy shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Policy.

- A person whose Coverage was terminated due to a violation of a material provision of this Policy shall not be eligible to enroll with the Plan for Coverage under this Policy.
- A person who is on active duty in the armed forces of any country shall not be eligible to enroll.
- Except as otherwise specifically stated in the Policy or as required by law, initial enrollment is limited to individuals who are not eligible for Title XVIII of the Social Security Act 49 Stat. 620 (1935), 42 USCA 301 as amended (Medicare) or any similar program sponsored by the federal government or a state government.

Special Enrollment

New Spouse Due to Marriage. Subject to the Medical Underwriting provisions noted above, the Policy Holder's new Spouse may enroll at any time after marriage.

New Dependents Due to Birth. A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

New Dependents Due to Adoption. A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

Notification of Change in Status

A Covered individual 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 Covered individual.

TERMINATION OF COVERAGE

Termination of Coverage	This Policy shall be renewable at Your option, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the individual under this Policy. Your Coverage shall terminate if any one of the following events occurs:
<i>Loss of Eligibility</i>	If You no longer meet the eligibility requirements set forth in this Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.
<i>Non-Payment</i>	You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, You will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.
<i>Change in Status</i>	You change Your place of residence outside our Service Area.
<i>Non-Compliance</i>	Coverage under this Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If Your Coverage is Rescinded, as described in this section, Coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on Your behalf. Therefore, both You and the Plan will be returned to a financial position as if no Coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, Your Coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two (2) years. This exception does not apply in the case of fraudulent misrepresentation.
<i>Misrepresentation</i>	You participate in fraudulent or criminal behavior, including but not limited to: <ul style="list-style-type: none">▪ Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.▪ Allowing any other person to use Your identification card to obtain services. If You allow any other person to use Your identification card to obtain services, Your Coverage will be terminated.▪ Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.
<i>Criminal Behavior</i>	You participate in criminal behavior, including but not limited to 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 Policyholder and all Dependents will be terminated.
Effect of Termination	If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination. Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

TERMINATION OF COVERAGE

Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Claims and Appeals procedures. The Plan may not terminate the Policy solely for the purpose of effecting Your disenrollment for either of these reasons.

If You receive Covered Services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance coverage in the individual 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. Termination of the Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the Policy.

Certificates of Creditable Coverage

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

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules listed below determine which plan will pay as the primary plan. The primary plan 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.

COB Definitions

Plan 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 participants 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 \$200 per day; school accident-type coverage; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
- "Plan" does not include: group or group-type accident only coverage; individual or family insurance; closed panel or other individual coverage; amounts of hospital indemnity insurance of \$200 or less per day; benefits for non-medical components of group long-term care policies; group and individual "no fault" contracts and group or group-type traditional automobile "fault" contracts; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
- Each contract for coverage is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.
- The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
- When this plan is primary, its benefits are determined before those on any other plan and without considering any of the other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

Allowable Expense

A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example a 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 allowable expenses:

- If a covered person 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 Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
- If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one plan calculates its benefits or services on the

COORDINATION OF BENEFITS

basis of usual and customary fees and the other plan provides its benefits or services on the basis of negotiated fees, any amount in the excess of the highest of the fees is not an allowable expense.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider organizations.

Claim Determination Period

A calendar year; however, it does not include any part of a year during which the participant has no Coverage under this plan or before the date this COB provision or similar provision takes effect.

Closed Panel Plan

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 the case of emergency or referral by a panel member.

Custodial Parent

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.

ADEA Employer

An employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA), and has twenty (20) or more Employees each working day in twenty (20) or more calendar weeks during the current or preceding Benefit Period.

Medicare Benefits

Benefits for services and supplies which You receive or are entitled to receive under Medicare Parts A or B.

Order of Benefit Determination Rules

When two (2) 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 regulation 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 basic package of benefits provided by a 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 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.
 - **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, (e.g. as an Employee, Participant, Subscriber or Retiree) is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person 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 person as an Employee, Participant or Subscriber, or Retiree is secondary and the other plan is primary.
 - **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

COORDINATION OF BENEFITS

- o The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - the parents are married;
 - the parents are not separated (whether or not they ever have been married); or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
 - o 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. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. This rule applies to Claim determination periods or plan years commencing after the plan is given notice of the court decree.
 - o 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:
 - the plan of the custodial parent;
 - the plan of the spouse of the custodial parent;
 - the plan of the non-custodial parent; and then
 - the plan of the spouse of the non-custodial parent.
 - **Active or Inactive Employee.** The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person 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. Coverage provided to an individual as a retired worker or as a Dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.
 - **Continuation Coverage.** If a person 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 person as an Employee, Participant or Subscriber, or Retiree (or as that person'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.
 - **Longer or Shorter Length of Coverage.** The plan that covered the person as an Employee, Participant, Subscriber or Retiree longer is primary.
- 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.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits on a Claim so that the total benefits paid or provided by all plans are not more than 100% of the total allowable expenses. The difference between the benefit payments that this plan would have paid had this 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

COORDINATION OF BENEFITS

claim determination period. As each Claim is submitted, this plan will:

- Determine its obligation to pay or provide benefits under its contract.
- Determine whether a benefit reserve has been recorded.
- Determine whether there are any unpaid allowable expenses.
- The benefits of the secondary plan will be reduced, so that they and the benefits payable under the other plans do not total more than 100% of the allowable expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and is charged against any applicable benefit limits or maximums. This plan will not pay more as secondary than it would have paid had it been primary.

If a covered person is enrolled in two (2) 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 the other closed panel plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

This Provision applies when You have Coverage under this document and are eligible for hospital insurance under Medicare Part A (whether or not You have applied or are enrolled for Medicare Benefits.) This Provision applies before any other COB provision of the policy.

If, in accordance with the following rules, the Plan has primary responsibility for Your Claims, then the Plan pays benefits first. If, in accordance with the following rules, the Plan has secondary responsibility for Your Claims; first Medicare benefits are determined or paid and then the Plan's benefits are paid. However, for services payable under both plans the combined Medicare Benefits and the Plan's benefits will not exceed 100% of total allowable expenses.

COORDINATION OF BENEFITS

Rules for Determining Order of Benefits

Subscriber: We have primary responsibility for Claims if the Subscriber is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for Claims when a Subscriber is eligible for Medicare Part A or B, and is not actively employed by an ADEA employer who pays all or part of the Group Contract's premium.

Dependent: We have primary responsibility for a Dependent's Claim if the Dependent is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for a Dependent's Claims when he or she is eligible for Medicare Part A or B, and the Subscriber is not actively employed by an ADEA employer who pays all or part of the Agreement's premium.

Persons with End-Stage Renal Disease: We have primary responsibility for the Claims for You for up to thirty (30) months from the date You begin a regular course of renal dialysis or You could be entitled to Medicare after receiving a kidney transplant. Medicare benefits are secondary only for that portion of the thirty (30) month period remaining after You become eligible for Medicare. Thereafter, Medicare benefits are primary, and the Plan's benefits are secondary.

Persons under Non-ADEA employer plans: We have secondary responsibility for Your Claims if the employer under the Agreement is not an ADEA employer.

CLAIMS AND APPEAL PROCEDURES

You may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, You or Your Authorized Representative may call or write the Plan to file a complaint or an appeal. We will provide You a full and fair review of Claims decisions and Appeal decisions as required under ERISA. If You receive Your health benefits coverage through any arrangement that is not subject to ERISA, You have the same Claims and Appeal rights as a matter of contract. Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Policy.

Definitions

Administrative Appeal

For the purposes of this section, the following terms and their definitions will apply:

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

Adverse Benefit Determination

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services;
- The failure, reduction, or termination regarding terms of the contractual relationship between You and the Plan; and/or
- Rescission of coverage.

Appeal

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

Claim for Benefits or Claim(s)

A request for a service or payment of a service You make in accordance with the Plan's procedure for filing Claims. A Claim includes urgent care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this document.

Claim Eligible for External Review

(1) In the case other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which You have received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, or (2) in case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Plan that a proposed health care service, which would otherwise be covered under this Certificate, is not Medically Necessary or the health care treatment has been determined by the Plan to be Experimental or Investigational and the denial would leave You with a financial obligation or prevent You from receiving the requested service.

Complaint

Any dissatisfaction expressed by You or Your Authorized Representative regarding a

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	Plan issue.
<i>Expedited Appeal</i>	An Appeal that may be requested either orally or in writing if You feel Your condition requires urgent care.
<i>External Review</i>	The review of an Adverse Decision by an external review organization, which conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Department of Insurance.
<i>Inquiry</i>	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.
<i>Medical Necessity Appeal</i>	An Appeal of a determination by the Plan or its designated 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
<i>Post-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
<i>Pre-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization. Routine inquiries about Coverage information do not constitute Pre-Service Claims.
<i>Urgent Care</i>	Care for a condition when a delay in receiving such care could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your condition, would subject You to severe pain that could not be adequately managed without care or treatment that is the subject of the Claim. In determining whether a Claim involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of Your medical condition determines a Claim involves urgent care, the Claim must be treated as an Urgent Care Claim.
<i>Urgent Care Appeal</i>	An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of You or Your unborn child; or (b) Your ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
<i>Urgent Care Claim</i>	A request for a Claims decision regarding urgent care.

Complaints

A Complaint is a verbal expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, You will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days

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thereafter. You will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than You, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:
 [P.O. Box 7109
 London, KY 40742
 Telephone: (800) 969-3343]

Process for Submitting an Appeal

You or Your Authorized Representative has the right to obtain, without charge, copies of the documents, relating to the Adverse Decision, including the name of the utilization review organization used to review the Claim and may Appeal an Adverse Decision from an initial Claims decision by:

- submitting the Appeal in writing to [8320 Ward Parkway, Kansas City, MO 64114] to the attention of the appeals committee;
- sending a fax to [816-769-2408]; or
- [sending an e-mail to] [KCCompliance@cvty.com].

If You believe Your health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, You may make an oral request for an Expedited Appeal by calling the Customer Service Department at the number on Your ID card.

Appeals should include:

- Your name and ID number.
- Specific information relating to and reason for the Appeal.
- Your expectation for resolution.
- Copies of medical records or other documentation that You wish to be considered in the Appeal.

The appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, You may be referred for a second opinion.

Appeal of Adverse Decisions

A decision on the Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date of the receipt of notification of the initial Adverse Decision)	180 days	180 days	180 days
Appeal Decision (from the date the Appeal is received by the Plan)	36 hours	15 days	20 working days

You may voluntarily agree to provide the Plan additional time within which to make a decision.

In the case of an Urgent Care Appeal, You and/or Your Authorized Representative will be notified verbally and will be provided a follow-up written notice within 36 hours of

CLAIMS AND APPEAL PROCEDURES

receipt of the Appeal request.

You will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than You, who submitted the Appeal will be notified.

Procedure for Pursuing an External Review

You have the right to request an External Review after a final Adverse Decision has been rendered, or when You have not received a final Adverse Decision within sixty (60) days of seeking such review, unless the delay was requested by You for eligible Claims as defined in the Claims Eligible for External Review section. We will notify You in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

Within one-hundred twenty (120) days of receipt of the notice of the final Adverse Decision, You, the treating Provider acting on Your behalf with written authorization from You, or Your legally authorized designee, must make a written request for an External Review to [Us] [the Arkansas Insurance Department].

The right to External Review shall not be construed to change the terms of Coverage under this document. In no event shall more than one (1) External Review be available during the same year for any request arising out of the same set of facts.

You may contact the State Insurance Department at anytime by mail or telephone:

- Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

UTILIZATION REVIEW POLICY AND PROCEDURES

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 Skilled Nursing Facility, 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 Prior Authorized by the Plan, after the services have been provided.

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.

Timing of Utilization Review Decisions

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

Prospective or Pre-Service Review

Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide You and the Provider written or electronic confirmation of the telephone notification within two (2) working days of making the initial certification.

Concurrent Care Review

Determination regarding an extended stay or additional services will be made within one (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to You until You have been notified of the determination. The Plan shall notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide You and the Provider written or electronic confirmation within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

Retrospective or Post-Service Review

Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide You written notice of determination within ten (10) working days of making the determination.

Notification

In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the Provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide You and the Provider written or electronic notification within one (1) working day of the telephone notification.

UTILIZATION REVIEW POLICY AND PROCEDURES

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.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

Right to Appeal

You also have the right to an expedited or standard Appeal. Please see the Claims and Appeal Procedures Section of this document for the time frames for Appeals. Reconsideration is not a prerequisite to any Appeal.

Denial of Claims

The Plan's Medical Director shall make decisions regarding the denial of Coverage when related to Medical Necessity. Notices of claim denials shall include information regarding the basis of the decision and further Appeal rights.

Technology Assessment

The Plan uses a technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including but not limited to, medical procedures, drugs and drug therapies, and devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical databases, specialty medical societies, applicable government publications, the Plan Medical Directors, Pharmacy Department, and specialists, researchers, or institutions that specialize in the condition involved as needed.

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

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

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

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

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

UTILIZATION REVIEW POLICY AND PROCEDURES

[Case Management

Case management is a program conducted by the Plan that:

- Identifies cases involving a patient in a clinical situation that presents either the potential for catastrophic Claims or a utilization pattern that exceeds the norm.
- Assesses the appropriateness of the level of patient care and the setting in which it is received.
- Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care through discussion and Policy with You or Your legal representative, Provider(s), and the Plan.

This treatment plan may include both Covered Services and Non-Covered Services. Payment of benefits for such services or supplies shall be subject to the terms and provisions of this document.]

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Applicability	The provisions of this Policy shall apply equally to the Policyholder and Dependents and all the benefits and provisions made available to You shall be available to Your Dependents.
Governing Law	This Plan is delivered and governed by the laws of the State of Arkansas.
Limitation of Action	You must exhaust the Plan's Claims and Appeals Procedure prior to pursuing legal action, (in a court or other government tribunal). No action at law or in equity shall be brought to recover under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.
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 Policy. Such right to health care service Coverage or other benefits is not transferable.
Relationship Among Parties Affected by Policy	<p>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.</p> <p>You are not an agent or representative of the Plan, and neither shall You be liable for any acts or omissions of the Plan for the performance of services under this Policy.</p>
Reservations and Alternatives	The Plan reserves 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 You. You must cooperate with those persons or entities in the performance of their responsibilities.
Severability	In the event that any provision of this Policy is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Policy, which shall continue in full force and effect in accordance with its remaining terms.
Valid Amendment	No change in this Policy shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Policy and/or by Amendment to this Policy. Such Amendments will be incorporated into this document. Amendments to this document are effective upon thirty-one (31) days written notice to You. No change will be made to this document unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change this document or to waive any of its provisions.
Waiver	The failure of the Plan or You to enforce any provision of this Policy 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 Policy shall

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not be deemed or construed to be a waiver of such default.

Entire Policy

This Policy shall constitute the entire Policy between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Policy that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Your Coverage shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, or unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

Participation in the Policies of the Plan

If You wish to participate in matters of the Plan's policies and operations, You may do so by submitting suggestions, in writing, to the Customer Service Department at the address located in the Schedule of Important Numbers. The Plan's Quality Improvement Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body.

Records

You 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 document in the event the Plan is unable to obtain this information directly from the Provider or insurer.

By accepting Coverage under this document, each individual, including enrolled Dependents, whether or not such enrolled Dependents have signed the application of the Policyholder, authorizes and directs any person or institution that has provided services to You, 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 You. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of this document or for appropriate medical review or quality assessment.

Examination

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine You at the Plan's expense.

Clerical Error

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

Workers' Compensation

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

Conformity with Statutes

Any provision of this document 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.

Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of

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age, color, disability, gender, marital status, national origin, religion, sexual preference, genetic information, or public assistance status.

Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by You or on Your behalf, 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 services, the Plan will pay for such 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.

Policies and Procedures

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

Value Added Services

From time to time the Plan may offer to provide You 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 You 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 You 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.

Applications and Statements

You shall complete and submit to the Plan such applications, or other forms or statements, as the Plan may reasonably request. The only statements You make that may be used in any legal action concerning this document issued hereunder are statements that are in writing. Any such written statement will be considered a representation and not a warranty.

Cooperation with Claims Investigation

You shall cooperate with the Plan in the benefit determination process and regarding the investigation of Claims relating to Covered Services, Coordination of Benefits, Medical Necessity determinations, utilization review and fraud and abuse functions. This duty to cooperate includes, but is not limited to, providing upon request by the Plan a written statement and/or testimony under oath regarding any Claim where Your name, identification or identity is utilized. Failure to cooperate may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Federal and State Law Requirements

You shall provide the Plan with any information that is required for Us to comply with federal or state law requirements. Failure to provide the required information may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Time Limit on Certain Defenses

Except for fraud, no statement shall be used to deny Your Claim after two (2) years. The two (2) years start from the date of Your application for submission of evidence for reinstatement.

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No claim for loss incurred or disability (as defined in this document) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Policy.

GLOSSARY

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

Activities of Daily Living	Activities You usually do during a normal day including but not limited to bathing, dressing, eating, grooming, maintaining continence, toileting, transferring, and mobility.
Allowed Amount(s)	The maximum monetary amount the Plan calculates for Covered Services, either in accordance with the Participating Provider's contract or the Non-Participating Provider Fee Schedule, when rendered to individuals and/or authorized by the Plan.
Alternate Facility	<p>A duly-licensed 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:</p> <ul style="list-style-type: none">▪ Scheduled surgical services;▪ Emergency services;▪ Urgent Care Services;▪ Prescheduled rehabilitative services;▪ Laboratory or diagnostic services;▪ Inpatient or outpatient Mental Illness services or Substance Abuse services.
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.
Amendment or Endorsement	Any attached written description of additional or alternative provisions to the Policy and/or this document. Amendments or Endorsements are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.
Ancillary Provider	A Provider who is not licensed as a Physician or a Hospital.
Authorized Representative	An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for HIPAA privacy purposes.
[Basic Health Services	Services which You may reasonably require in order to be maintained in good health, including as a minimum, inpatient Hospital, Physician, outpatient services, and Emergency services that are Covered under this document. Benefits provided by Riders attached to this document are not considered Basic Health Services for the purpose of this definition.]
Benefit Period	The period of time (typically twelve (12) months) during which certain Allowed Amount(s) for Covered Services are accumulated for purposes of determining Coverage provisions, such as, but not limited to, satisfaction of out-of-pocket maximums and benefit limits. Refer to Your Schedule of Benefits to determine the applicable Benefit Period.

Benefit Period Maximum	A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for You in any one year. Once a Benefit Period Maximum is met, no more Covered Services will be provided during the same year.
Coinsurance	Cost-sharing arrangement in which You pay a specified percentage of the cost for a Covered Service.
Coinsurance Maximum	The annual limit of Your coinsurance payments for Covered Services, as specified in the Schedule of Benefits.
Confinement and Confined	An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.
Copayment	Cost-sharing arrangement in which You pay a specified dollar amount as Your share of the cost for a Covered Service.
Coverage or Covered	The benefits provided under this document for Covered Services rendered to You, subject to the terms, conditions, exclusions, and limitations of this document.
Covered Services	The services or supplies provided to You for which the Plan will make payment, as described in the Policy.
Custodial Care	Care is considered custodial when it is primarily for the purpose of helping You 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 You who, in the opinion of the Medical Director, has reached the maximum level of recovery. This term also includes services to an institutionalized individual, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to; respite care and home care which is or which could be provided by family members or private duty caregivers; and vacation or resort facilities that incorporate recreational therapy or rest cures.
Day Program Services	A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.
Deductible	The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Policy.
Dependent	A person defined in the Policy who is eligible to receive Covered Services (usually the spouse or child of a Policyholder).
Designated Transplant Network Facility	A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of

Important Numbers.

Designated Transplant Network Physician

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

Effective Date

The date of Coverage as determined by the Plan and agreed to by You, as set forth in the Policy.

Emergency Medical Condition and Medical Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing Your health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:
 - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 - That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Some examples of an Emergency Medical Condition include, but are not limited to: broken bone; chest pain; seizures or convulsions; severe or unusual bleeding; severe burns; suspected poisoning; trouble breathing; and vaginal bleeding during pregnancy. You may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

Emergency Services

Ambulance services and other Health Care Services rendered or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician, subject to the exclusions and other provisions set out in this document.

Experimental or Investigational

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

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, except as otherwise covered under the Clinical Trial benefit;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 and its administrative

regulations.

Home Health Agency

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

Hospital

An institution, operated pursuant to law, which: (a) is operated for the medical treatment of sick and/or injured persons as inpatients; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, 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.

Maintenance Therapy

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Medical Director

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Prior Authorization programs.

Medically Necessary/Medical Necessity

Those services, supplies, equipment and facility charges that are not expressly excluded under this Policy 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 basic health needs as a minimum requirement;
- 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 without compromising the quality of care;
- 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.

[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.]

Officer

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

Out-of-Pocket Maximum

The annual limit of Your payments for Covered Services, as specified in the Schedule of Benefits.

GLOSSARY

Participating Provider	A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to individuals.
Peer-Reviewed Medical Literature	<p>A phrase defined by two elements:</p> <ul style="list-style-type: none">▪ It refers to the requirement that medical literature on a topic is only considered relevant if it is 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; and▪ Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: <u>strength</u> of the evidence and <u>effectiveness</u>. Strength of evidence is graded from the highest level of evidence to the lowest, as follows: Level 1: Randomized, controlled trial Level 2: Cohort/Case Control Study Level 3: Systematic Literature Review Level 4: Large consecutive case series Level 5: Small consecutive case series Level 6: Textbook chapters (opinion of a respected authority) Level 7: Case report <p>Effectiveness is evaluated using 4 measurements: (1) Is the proposed treatment harmful or beneficial? (2) Do the results favor the study (experimental) group or the control group? (3) Is the outcome considered statistically weak or strong? (4) Is the study design weak or strong?</p> <p>After evaluating the peer-reviewed medical literature according to the methodology described above, a conclusion is drawn that the preponderance of evidence favors the proposed new technology as being proven (and therefore standard of care), or conversely unproven (i.e. investigational/experimental).</p>
Physician/Practitioner	<p>Anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.</p> <p>By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Policy, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.</p>
Plan	Coventry Health & Life Insurance Company.
Policy	This document and Amendments, Application for Coverage and/or Change Form, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Policy.
Premium	The monthly fee required by the Plan for You and each enrolled Dependent in

	accordance with the terms of the Policy.
Preventive Services	The services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered is available on the website [www.chckansas.com] or will be mailed to You upon request.
Prior Authorization	The process of obtaining approval for receiving specific health care services prior to those services being rendered. The process includes determination of eligibility, determination of Covered Services, determination of Medical Necessity, and implications about the use of Participating and Non-Participating Providers. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.
Provider	A Physician, Hospital, Home Health Agency, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.
Provider Directory	A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.
Public Entity	A publicly supported medical facility providing care, treatment and supplies to injured or sick individuals through a program or agency owned and operated by a state or county government. This may include but is not limited to entities such as a county hospital or county health clinic.
Residential Treatment Facility	A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.
Residential Treatment Program	A program certified by the department of mental health involving residential care and structured, intensive treatment.
Rider	An Amendment that provides additional Covered Services and is attached to the Policy. Services provided by a Rider may be subject to payment of additional Premiums.
Schedule Of Benefits	A written document, incorporated by reference into this document, that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.
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.
Skilled Nursing Facility (SNF)	A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.
Special Enrollment Period	The period after the regular Enrollment Period during which an individual is allowed to

GLOSSARY

enroll for Coverage subject to the terms of this document.

**Specialty Care
Physician/Specialist**

A Physician who is not a Primary Care Physician and provides medical services to individuals concentrated in a specific medical area of expertise.

Substance Abuse

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.

Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Prior Authorization, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

We, Us or Our

Coventry Health & Life Insurance Company.

You or Your

An individual covered under this document.

SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

[Customer Services/Claims Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD
www.chckansas.com]

[Prior Authorization Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD]

[Appeals and Grievance Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114]

[MH Net Behavioral Health PO Box 209010
Austin, TX 78720
(866) 607-5970
www.chckansas.com]

**[Arkansas Insurance
Department]** 1200 West Third St
Little Rock, AR 72201
(800) 282-9134
Insurance.Consumers@arkansas.gov

Outline of Coverage for Individual Health Benefit Policies

Arkansas



CoventryOne® is underwritten by Coventry Health and Life Insurance Company and administered by [Coventry Health Care of Kansas, Inc].

IMPORTANT NOTICE

This summary is a partial description of the CoventryOne Policy underwritten by Coventry Health and Life Insurance Company, and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the Individual Policy, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

[INSERT FORM CHL-AR-SOB-003-10.10]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by Coventry Life and Health Insurance Company. Your new policy provides ten (10) days within which you may decide without cost whether you desire to keep the policy. For our own information and protection you should be aware of any seriously consider factors which may affect the insurance protection available to you under the new policy.

- Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write Coventry Health & Life Insurance Company, [CoventryOne Medical Underwriting, PO Box 7109, London, KY 40742], or call us at [(800) 969-3343], within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Read Your Policy Carefully

This outline of coverage provides a very brief description of important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

Major Medical Expense Coverage

Policies of this category are designed to provide to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

Termination of Policy and Renewal

This Policy shall be renewable at the option of the Insured, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the Insured under this Policy. Your Coverage shall terminate if any one of the following events occurs:

- **Cancellation.** You may cancel this Policy at any time by written notice delivered or mailed to the Plan, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the Insured, the Plan will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- **Loss of Eligibility.** If You no longer meet the eligibility requirements set forth in the Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.
- **Rescission of Coverage.** Coverage for an Insured under the Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If an Insured's coverage is Rescinded, coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on the Your behalf. Therefore, both the Plan and the Insured will be returned to a financial position as if no coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, an

Insured's coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two years. This exception does not apply in the case of fraudulent misrepresentation.

- **Non-payment of Premiums.** You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.
- **Fraud.** You participate in fraudulent or criminal behavior, including but not limited to:
 - Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.
 - Allowing any other person to use Your identification card to obtain services. If the Insured allows any other person to use his/her identification card to obtain services, the Coverage of the Insured will be terminated.
 - Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.

Exclusions and Limitations

Pre-Existing Conditions Limitation

Pre-Existing Conditions may affect your premium rate, may result in denial of your application, or we may deny Coverage for them for a period of time after your effective date. If you are accepted for Coverage, your premium rate will be calculated to include any Pre-Existing Condition that you disclosed on your enrollment form, and such conditions will be Covered under the terms of your Policy beginning on your effective date. Any Pre-Existing Condition(s) that is not disclosed on your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after your effective date.

Note: Effective September 23, 2010 The Pre-Existing Conditions limitation does not apply to persons age eighteen (18) or younger.

The following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy.
- Any service or supply that is not Medically Necessary.
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service and subsequent complications which may occur.
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational.
- Court-ordered services including forensic or custodial evaluations; evaluations and diagnostic tests ordered or requested in connection with criminal or legal actions; damages in any kind of personal injury action, divorce, child custody, paternity, severance of parental rights, or child visitation proceedings; or services that are a condition of probation, parole or diversion agreements.
- Those services otherwise Covered under the Policy related to a specific condition when You have refused to comply with, or have terminated the scheduled service or treatment against the advice of a Provider or the Mental Health/Substance Abuse Designee.
- Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates.
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as You, or rendered by a person who is a member of Your family, including spouse, brother, sister, parent, stepparent, child or step-child.
- Any portion of a Claim that the Plan determines to be incorrectly or inappropriately billed by a Physician, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

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

Abortion	Services related to elective abortions unless covered under an attached Rider. An elective abortion is a termination of pregnancy for any reason other than a spontaneous abortion (miscarriage) or to prevent the death of the individual upon whom the abortion is being performed.
Alternative Therapies	All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupuncture, acupressure, hydro-massage, hypnotherapy, hypnosis, massage therapy, Vax-D therapy, reflexology, cranio-sacral therapy, and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
Apparel	Items of wearing apparel including, but not limited to TENS unit sleeves, except as specified in the Covered Services section
Augmentative Communication Devices	Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled individuals.
Autopsy	Those services and associated expenses related to the performance of autopsies, unless requested by the Plan, to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan.
[Biofeedback]	Any expenses related to biofeedback.]
Chelation Therapy	Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
Counseling	Expenses related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
Custodial Care	Domiciliary care, convalescent care, residential care, respite care or rest care. This includes care that assists You 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 whether or not required by a Physician.
Duplicate Benefits	Benefits of this document will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This document will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services.
Eligible Expenses	Any otherwise eligible expenses that exceed the maximum allowance or benefit limit.
Food	Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for in the Covered Services Section.
Foreign travel	Care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services.
Fraud	Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or intentional fraud.
Halfway House	Services rendered or billed by a school or halfway house.
Hair analysis	Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
Health Club Membership	Any costs of enrollment in a health, athletic or similar club.
Household Equipment and Fixtures	Purchase or rental of household equipment including, but not limited to: fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hot tubs, hypo-allergenic pillows, pools, power assist chairs, mattresses or waterbeds, car seats, strollers, shower chairs, commodes, breast pumps, bedwetting alarms, prenatal cradles, electronic communication devices, braces and supports

Illegal Acts	needed for employment, and modifications to Your home or vehicle. Injuries incurred while You are in the commission or attempted commission of a felony, except when the injury is the result of You being a victim of domestic violence.
Immunizations	Those immunizations for travel, employment or education unless otherwise Covered under the Covered Services Section.
Maternity Services	Expenses incurred for any condition of or related to pregnancy, including childbirth, routine pregnancy visits, nursery care charges, and delivery whether by vaginal or Cesarean birth, or selective reduction. Complications due to or developed during pregnancy are Covered like any other illness.
Medical-Legal	Services rendered primarily for the purpose of medical-legal reasons including, but not limited to, a Provider/patient contract to determine and monitor compliance with prescribed drug treatment, or for the purpose of Provider malpractice protection, that lack medical necessity as defined by this document. This does not include monitoring for therapeutic medication levels, which are deemed Medically Necessary.
Military Health Services	Those services for treatment of military service-related disabilities when You are legally entitled to other Coverage and for which facilities are reasonably available to You; or those services for any otherwise eligible individual or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act.
Miscellaneous Service Charges	Miscellaneous service charges including, but not limited to, consultations performed through use of telephone, fax, or email communication; case management team conferences; consultations with family members; charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service); or any late payment charge.
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.
Non-Medical Ancillary Services	Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, educational testing, training, or therapy, unless approved by the Plan as part of treatment for traumatic head injury or stroke, or as specified in the Covered Services section.
Non-Prescription Drugs and Medications	Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional Pharmacy Rider.
Nutritional-Based Therapy	Nutritional-based therapies except for treatment of 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 regardless of whether it is the sole source of nutrition except as provided for under PKU or any other Amino and Organic Acid Inherited Disease Food/Formula.
Nutritional Supplements	Vitamins, minerals, nutritional supplements, medical foods, breast milk and formulas, or special diet foods whether or not required by a Physician except as required to be covered by law.
Obesity Services	Those 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, jejuna bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and

Over-the-Counter Supplies	supplies of a similar nature. ACE wraps, batteries, elastic supports, finger splints, orthotics, and braces; also over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, therabands, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider.
Pain Management Personal Comfort and Convenience	Costs associated with commercial pain management programs. Services or items for the Provider's or Your convenience including items or services such as home laboratory testing, television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Prescription Drugs and Medications	Prescription and non-prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider to the Policy.
Private Duty Nursing	Private duty nursing services, whether or not required by a Physician; nursing care on a full-time basis in Your home; or home health aides.
Rebating	Any service(s) rendered where You receive monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).
Replacement Items Sex Transformation Services	Costs associated with the replacement of items that are damaged, lost, or stolen. 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.
Sexual Dysfunction	Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasm.
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 including braces, supports and orthotics.
TMJ and MPDS	Services related to the diagnosis and treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) unless covered by an attached Rider.
Third Party Liability	Services for which a third party has liability (by whatever terminology used-including such benefits mandated by law).
[Tobacco Cessation	Those services and supplies for tobacco cessation programs and treatment of nicotine addiction.]
Travel or Transportation Expenses	Transportation, food, and lodging expenses even though prescribed by a Participating Provider, except as specified in the Covered Services Section.
War or act of war	Services received as a result of war or any act of war when You are outside of the continental United States, whether declared or undeclared or caused during service in the armed forces of any country.
Workers compensation	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 program.



Submit your completed Change Request Form to:

E-mail: planchanges@cvty.com
FAX: 877-815-8747
Address: ATTN: Plan Changes
CoventryOne Individual Underwriting
P.O. Box 61440, TecPort Drive
Harrisburg, PA 17106-1440

Underwritten by Coventry Health & Life Insurance Company

[Health Plan Name] [Special State or Association Name]

Change Request Form

Important: Please print clearly in BLACK ink. Refer to your contract for eligibility requirements. Please keep a copy of this form for your records.

Check all that apply (up to three (3) changes are permitted per form):

- Contact Information / Name Change Newborn Addition Remove / Move Dependents Decrease Benefits / Cancel Coverage Other

Primary Member Information This section is **required** for all requested changes and must reflect the information on your ID card.

Last name	First name	MI	Member ID number	Primary phone () -
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Address / Name Change Complete this section for changes in name, phone number, E-Mail, home address or mailing address.

Member name change (indicate both previous and new name)	New phone number	New E-mail address
New home address (Street, City, State, ZIP)	New mailing address (Street, City, State, ZIP)	

Newborn Addition Complete this section to add a newborn or newly adopted child to your coverage. Requests must be received within 31 days (60 days in Iowa / 90 days in Arkansas) of the date of birth or a new Application must be submitted and will be subject to medical underwriting.

Last name	First name	MI	Gender M F	Birthdate (mm/dd/yyyy)	Social Security Number
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Remove / Move Dependents Complete this section for changes to current dependents.

Full name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)	Change requested (select ONE only)	Requested Effective Date of Change (mm/dd/yyyy)
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> Remove from policy; discontinue coverage	
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> Remove from policy; discontinue coverage	
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> Remove from policy; discontinue coverage	

Decrease Benefits or Cancel Coverage A request for a reduction in benefits or cancellation of coverage must be submitted by the end of the month prior to the requested effective date of change. Retroactive benefit reductions and terminations are not permitted. Benefit plan changes affect all covered members. Decreasing your benefits does not change your renewal date, at which time your rates will be recalculated.

<input type="checkbox"/> Decrease my benefits. Requested Effective Date _____ Change plan to: _____	<input type="checkbox"/> Cancel my coverage. Requested date of cancellation _____ Reason for cancellation: _____
---	--

Other Explain other requested changes in the space below. Note that certain changes require submission of a new Application for Health Coverage. These changes include addition of a spouse, an increase in benefit level and addition of a new dependent after 31 days of birth or adoption. Changes to banking information should be submitted on a new Banking Information Form.

--

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

_____ Primary Applicant's Signature	_____ Date	_____ Spouse's Signature	_____ Date
_____ Dependent Applicant Signature**	_____ Date	_____ Dependent Applicant Signature**	_____ Date

**Required age 18 and over.

SERFF Tracking Number: CVKS-127719573 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/04/2011
Comments:			
Attachment:			
FLESCH.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/04/2011
Bypass Reason:	n/a to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Accepted for Informational Purposes	11/04/2011
Bypass Reason:	n/a to this filing		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	11/04/2011
Comments:	See Form Schedule Tab. Form listed for review and approval		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/04/2011
Bypass Reason:	n/a to this filing		

SERFF Tracking Number: CVKS-127719573 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

Comments:

	Item Status:	Status Date:
Satisfied - Item: Coverletter 2011 10 13	Approved-Closed	11/04/2011

Comments:

Coventry respectfully submits a new Individual Policy for review. This has several bracketed variables in which will either be written as indicated or removed. Variables are described with a range indicate a numerical flexibility with minimum and maximum range placed within.

There is no rate impact to this filing.

The intent is to offer more readability to applicants/participants in hopes they better understand the benefits being offered.

	Item Status:	Status Date:
Satisfied - Item: SOB and TMJ Rider	Approved-Closed	11/04/2011

Comments:

Previously filed and approved under CVKS-126855093 and will be used with this filing.

Attachments:

CHL-AR-SOB-003-10.10.pdf
 CHL-AR-RID-005-10.10.pdf

	Item Status:	Status Date:
Satisfied - Item: Rate	Approved-Closed	11/04/2011

Comments:

Attached per Filer Note, for documentation.

Attachment:

2011 01 01 (Rev 2).pdf



Underwritten by Coventry Health and Life Company and administered by [Coventry Health Care of Kansas, Inc.]

PPO Schedule of Benefits
[Plan Name]
State(s) of Issue: Arkansas

Benefit	Insured Responsibility	
	Participating Providers	Non-Participating Providers ²
[Policy Deductible^{4]} ((per Calendar Year) [per Contract Year] [Benefit Year])	[Individual:] [\$0 - \$15,000] [Family:] [\$0 - \$45,000]	[Individual:] [\$0 - \$30,000] [Family:] [\$0 - \$60,000]
[Coinsurance] [and] [Copayment] For All Eligible Expenses (unless otherwise noted)	[\$0-\$200] [Copayment] [and] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [0%-70%] [Coinsurance] [AD ³]
[Coinsurance] [Out-of-Pocket^{4]} Maximum ((per [Calendar Year] [Contract Year] [Benefit Year]))	Individual: [\$0 - \$30,000] Family: [\$0 - \$60,000]	Individual: [\$0 - \$30,000] Family: [\$0 - \$60,000]
Physician Office Services¹		
§ Primary Care Physician Office Visit ¹	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Specialist Physician Office Visit ¹	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ X-ray & Laboratory Services	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Allergy Injections	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ All Other Covered Services - Including but not limited to: Allergy Testing, Therapeutic Injections, Office Surgery	[Same as Physician Office Visit ¹] [\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[Same as Physician Office Visit ¹] [\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
Preventive Care		
§ Preventive Care – Including all Preventive Services described in the Covered Services Section of the CoventryOne Policy.	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Immunizations-Adult	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]

§ Immunizations-Pediatric (Up to age 72 months)	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Mammogram [Diagnostic] [and] Routine Screening	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Colonoscopy [Diagnostic] [and] Routine Screening	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
Outpatient Laboratory Services		
§ In a Physician's Office	[Same as Physician Office Visit ¹] [\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[Same as Physician Office Visit ¹] [\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ At a Free Standing Facility	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ At a Hospital Facility	[\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
Outpatient Services At Hospital or Free Standing Facility		
§ Radiology	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Diagnostic Services	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
§ Dialysis	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]]

<p>§ Surgery and Scopes</p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>
<p>Inpatient Hospital Care</p>		
<p>§ Inpatient hospital care, including semi-private room & board, intensive/coronary care, [maternity care,] x-ray, laboratory, professional services and other facility & ancillary charges.</p> <p>§ Inpatient Rehabilitation [Limited to [10 – 200] days per [Calendar Year] [Contract Year]][Benefit Year]]</p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Per Admission] [Per Day] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p> <p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Per Admission] [Per Day] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>	<p>[\$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] [Per Admission] [Per Day] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p> <p>[\$0-4,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] [Per Admission] [Per Day] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>
<p>Urgent Care and Emergency Care Services</p>		
<p>§ Ambulance/Emergency Transportation (Ground or Air)</p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>

§ At an Urgent Care Center	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]
§ At a Hospital Emergency Room [(Copayment waived if admitted)]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]
§ [Emergency Room] [Related Professional Fees]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]
Short Term Therapies		
§ Physical Therapy, Occupational Therapy & Speech Therapy [Limited to [10 – 200] visits [per Therapy] per [Calendar Year] [Contract Year] [Benefit Year]]	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]
§ Cardiac and Pulmonary Rehabilitation [Limited to [10 – 200] visits per [Calendar Year] [Contract Year] [Benefit Year]]	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]

<p>§ Partial Day Programs (4 hours or greater) <i>[Limited to [10 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]</i></p>	<p>[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>
<p>§ Chiropractic Services/Spinal Manipulation <i>[Limited to [4 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]]</i></p>	<p>[Same as Specialist Physician Office Visit] [\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>	<p>[Same as Specialist Physician Office Visit] [\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>
<p>Other Services</p>		
<p>[Eye Exam] [including refraction] <i>[Refraction Services Limited to [1 – 6] exams every [12 – 48] Months]</i></p>	<p>[Same as Physician Office Visit¹] [\$0-\$200] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³]</p>	<p>[Same as Physician Office Visit¹] [\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³]</p>
<p>Injectable Medications (Not listed elsewhere)</p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>
<p>Skilled Nursing Facility <i>[Limited to [10 – 200] days per [Calendar Year] [Contract Year] [Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] [Per Admission] [Per Day] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] [Per Admission] [Per Day] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]]</i></p>

<p>Home Health Care <i>[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]</i></p>	<p>[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>
<p>Hospice § [Inpatient] <i>[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]</i> § [Outpatient] <i>[Limited to [10 – 365] days per [Calendar Year] [Contract Year] [Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>
<p>Durable Medical Equipment § The cost of Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food when the food and food products exceeds the income tax credit of \$2,400.</p>	<p>[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>
<p>Prosthetics & Braces</p>	<p>[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>	<p>[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i></p>
<p>Organ / Tissue Transplant <i>[Services provided at approved Coventry Transplant Centers] [only]</i></p>	<p>See Appropriate Benefit</p>	<p>[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i> <i>[See Appropriate Benefit]</i></p>

Please Note: Maximum Benefit Limits do not guarantee that all services will be approved to the Maximum number allowed under this plan. Coinsurance is based on the contracted allowed amount reimbursed to the provider, if applicable.

In order to receive the maximum benefits, it is Your obligation to ensure that any required Pre-Certification has been obtained. Please see the Pre-Certification requirements outlined in your Certificate of Coverage. ***[Failure to do so may result in a [10 - 50%] reduction in benefits [,up to a maximum of [\$100 – 500],] for that particular service.]***

1. Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP benefit will apply. If you receive this service from a Specialist, your Specialist benefit will apply.
2. When receiving services from non-participating providers, payment for Covered Services is limited to the lesser of the billed charge or the Out-of-Network rate less applicable Copayment, Coinsurance and/or Deductibles. Please refer to the Certificate of Coverage for additional details.
3. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the Deductible requirement.]
4. [If you have individual-only coverage, you must satisfy the individual deductible and/or out of pocket maximum before any benefits will be paid. If two or more family members are on the same policy, you must satisfy the entire family deductible and/or out of pocket maximum before any benefits will be paid.]



TMJ RIDER

This Musculoskeletal Disorders of the Face, Neck or Head Rider (“Rider”) is underwritten by Coventry Health and Life Insurance company and administered by [Coventry Health Care of Kansas, Inc.] and is made a part of Coventry Health and Life Insurance Company’s Policy. The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

DEFINITIONS

All definitions of the Policy to which this Rider is attached shall apply except to the extent such terms are explicitly superseded or modified by this Rider.

BENEFITS

Coverage is provided for medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology whether prescribed or administered by a physician or dentist, subject to the applicable benefits on the Schedule of Benefits.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the Policy ends.
2. Nothing herein shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the Policy, other than as stated above.

[Signature of Company Officer]

SERFF Tracking Number: CVKS-127719573 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50033
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
 (PPO)
 Product Name: Individual Policy
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/14/2011	Form	Individual Policy	11/01/2011	CHL-AR-POL-022-09.11.pdf (Superseded)



PREFERRED PROVIDER ORGANIZATION (“PPO”)

*PPO products are underwritten by Coventry Health & Life Insurance company
and administered by Coventry Health Care of Kansas, Inc.*

Arkansas

Carefully check the application agreement and write to Coventry Health & Life Insurance Company at the address listed below, within ten (10) days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application agreement. This application agreement is part of the Policy and the Policy was issued on the basis that answers to all questions and the information shown on the application agreement are correct and complete. You may return this Policy within ten (10) days of its receipt for a full refund of any Premiums paid if, after examining it, You are not satisfied for any reason.

**THIS BENEFIT DOCUMENT AND ALL ATTACHED RIDERS
SHOULD BE READ IN THEIR ENTIRETY.**

You have the full freedom of choice in the selection of any duly licensed health care professional. This benefit document has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers you use. Please consult this benefit document, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

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Amount of Premium	The monthly premium due for Your coverage under this Policy is stated in the proposal page and may be updated as explained below.
Payment of Premium	<p>The first premium payment(s) is due no later than ten (10) days after the effective date of Your Policy. (For example, Your policy begins July 1; Your premium is due by the 10th of July and must be paid by the 10th of each month.) Premium payments for subsequent months shall be due on the 10th day of each month.</p> <p>All premium payments must be automatically deducted from either a checking or savings account of a banking institution. If funds are not available at the time of the automatic deduction, You will receive a notice that payment is due directly to Coventry Health & Life Insurance Company. Payments should be sent to:</p> <p style="text-align: center;">Coventry Health & Life Insurance Company [P.O. Box 6512] [Carol Stream, IL 60197-6512]</p>
Grace Period	You are granted a Grace Period of ten (10) days to make payment of every premium due. This means that if Your premium is not paid on the date that it is due, You must pay it within the following ten (10) days. This Policy will remain in force during this Grace Period. If You do not pay Your total premium by the end of the Grace Period, Your coverage will be retroactively terminated to the date covered by Your last paid premium.
Changes in Premiums	The Plan reserves the right to change Premiums upon ten (10) days written notice to the Policyholder. We will automatically change the amount of Your Premium should a birthday place You into the next age classification upon which Premiums are based. We may also change the amount of Your Premiums, upon ten (10) days written notice, if the Premiums of Your entire age classification are changed.
Reinstatement	<p>If any renewal Premium is not paid within the time granted You for payment, a subsequent acceptance of Premium by the Plan or by any agent duly authorized by the Plan to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Plan 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 Plan, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the Plan has previously notified You in writing of its disapproval of such application.</p> <p>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 You and the Plan shall have the same rights hereunder 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 the Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.</p>

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Identification (ID) Card

Every individual receives an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. 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 cannot identify You as a participant of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343]; or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on Your ID card and in the Schedule of Important Numbers. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. 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 Policy.

How to Contact the Plan

Throughout this Policy, You will find that the Plan encourages You to contact Us 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 website 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 document.

Copayments, Coinsurance [and Deductibles]

You may be responsible for paying Copayments to Participating Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the Allowed Amount. [You may be responsible for the difference between the actual billed charges of a Non-Participating Provider and the Allowed Amounts.] [You must meet the applicable Deductible, as described in Your Schedule of Benefits, before benefits will be payable to Providers on Your behalf.] Specific Copayments[, Deductible] and Coinsurance amounts are listed in the Schedule of Benefits.

Prior Authorization

Prior Authorization is required for certain Covered Services as determined by the Plan. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Plan has the right to request and obtain whatever medical information it considers necessary to determine whether the service is Medically Necessary. You or the Participating Providers are required to obtain Prior Authorization for Covered Services. **You are responsible for verifying Prior Authorization has been obtained whenever You seek Covered Services from a Non-Participating Provider.** An up-to-date Prior Authorization List is available by contacting the Us at the telephone number listed on Your ID card or by visiting the Our website.

Any new, additional or extended services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All services identified in this document are subject to all of the terms, conditions, exclusions and limitations of the Plan.

It is important to note that under the terms of the Plan, Prior Authorization only determines Medical Necessity and appropriateness. All other terms of the Plan are

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then applied. If the Plan Prior Authorizes Covered Services, the Plan shall not subsequently retract the Authorization after the Covered Services have been received, or reduce payment unless: (1) Such Authorization is based on a material misrepresentation or omission about Your health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) Your Coverage under the Plan terminates before the health care services are provided.

To find out the amount of the penalty applied for failure to obtain Prior Authorization, please see [the Prior Authorization List or] the Schedule of Benefits.

If You are admitted for emergency care to a Non-Participating Facility, or in the case of an unexpected length of stay after a Prior Authorized admission to a Non-Participating Facility, the Plan may request that You be transferred to a Participating Facility for continuation of care when it is not medically contraindicated. If You refuse to be transferred to a Participating Facility, [the Plan will not cover any services beyond the proposed date of transfer][coverage will be provided] [at the Non-Participating level] [for services received after the proposed date of transfer].

Health Services Rendered by Participating Providers

You have access to the services of a Participating Provider of Your choice within the Provider network for Covered Services, subject to the terms, conditions, exclusions and limitations of the Policy. Participating Providers are contractually obligated to file all claims for You.

It is Your responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. To verify the status of the Provider, please contact the Customer Service Department or check the Plan's website.

Coverage for Services by Non-Participating Providers

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You must submit a Claim form to the Plan. It is Your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of Your claim. 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. A claim will not be denied based upon the Your failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan. [No claim will be paid if not received by the Plan within one (1) year] [and ninety (90) days] [after services are received.]

[Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary Providers and other Providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You are required to make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular Covered Service, You will be responsible for paying any amounts in excess of

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the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.]

[Non-Participating Physician and Other Health Care Professional Fees

The Out-of-Network rate is equivalent to 100% of the national average Medicare rate, based on the previous year's Resource Based Relative Value Scale (RBRVS) fee schedule for Physician and other health care professional services, as such services are defined in the American Medical Association's Current Procedural Terminology (CPT) manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the previous year, the rate will be calculated using the assigned Relative Value Units (RVU) and the previous year's Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the [Medispan] [Average Wholesale Price (AWP)] or other nationally recognized source as determined by the Plan. Payment for anesthesia services will be 200% of the previous year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment (DME), prosthetics, orthotics and supplies (DMEPOS) will be at the previous year's DMEPOS ceiling limit. Payment for Laboratory services will be at the previous year's Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.]

[Non-Participating Facility Fees

The Out-of-Network rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group (DRG) rates. Payment for outpatient services will be based on Ambulatory Payment Classification (APC) rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center (ASC) group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one Provider to the next, so please make sure You are aware of the billed charge for services You want to receive from Non-Participating Providers.]

Second Opinion Policy

You may seek a second medical opinion or consultation from the Plan's Participating Providers. In the event the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, the Plan will arrange for a referral to a Provider with the necessary expertise.

Participating Provider Terminations

The Plan or a Participating Provider may end the relationship with the other party after having supplied notice under applicable law; therefore the Plan does not promise that any specific Participating Provider will be available to render services to You. [If a Participating Provider no longer participates with the Plan, the Plan will provide immediate notice to You and assist You in selecting another Participating Provider.] The Plan will provide You continuation of care up to ninety (90) days by a Provider who is terminated from the network in those cases where such continuation of care is Medically Necessary

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and in accordance with the dictates of medical prudence and where You have special circumstances such as a disability, a life-threatening condition or is in the third trimester of pregnancy. You will not be liable to the Provider for any amounts owed for medical care other than the applicable Copayments, Coinsurance and/or Deductible as specified in the Schedule of Benefits.

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 Policy, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against You or a person, other than the Plan or intermediary, acting on Your behalf for services provided pursuant to this Policy. This Policy shall not prohibit the Provider from collecting [Coinsurance, Deductibles or] Copayments, as specifically provided in this document, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision 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 provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing You Coverage.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Policy. 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 Policy. The Plan shall have the right, subject to Your rights in this document, to interpret the benefits of this document and attached Riders, and other terms, conditions, limitations and exclusions set out in the Policy in making factual determinations related to the Policy, its benefits, and You; 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. Any termination of the Policy must be in accordance with the Termination of Coverage Section of this document. 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.

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The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Authorized, if required, (3) not expressly excluded in the list of Exclusions section, and (4) incurred while eligible for Coverage under the Plan. It is Your responsibility to verify whether a Covered Service requires Prior Authorization and should always reference the Authorization Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already obtained the Authorization. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service. Please note that the Covered Services are subject to all applicable provisions within this document, and any attached Schedule of Benefits, Riders, Amendments, or Endorsements.

Allergy

Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Exclusions:

- Sublingual drops.
- Non-Physician services and expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

Ambulance (air and ground)

For Emergency use, when transport by other means is not medically safe, and for non-Emergency transportation for the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care;
- To a more cost effective acute care Facility; or

When transportation is needed to a long term acute care or inpatient rehabilitation facility.

Exclusion:

Non-Emergency and non-medically appropriate ambulance services, regardless of who requested the services, including transport due to the absence of other transportation.

Blood and Blood Products Processing

Coverage is provided for administration, storage, and processing of blood and blood products in connection with Covered services.

Exclusions:

- Expenses related to personal blood storage, unless associated with a scheduled surgery.
- Fetal cord blood harvesting and storage.
- The cost of whole blood and blood products replacement to a blood bank.

Chemotherapy

Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.

Clinical Trials

Expenses associated with professional services, diagnostic laboratory and radiology tests, inpatient care, and administration of treatment and evaluation during the course of the treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever You receive medical care associated with an approved clinical trial, and which would be covered if such items and services were provided other than in connection with an approved clinical trial.

Exclusions:

- The costs of the Investigational drugs or devices themselves, or the costs of any

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non-medical services that might be required for You to receive the treatment or intervention.

- Transportation and/or lodging costs incurred while receiving such treatment.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in Your clinical management.
- Health care services customarily provided by the research sponsors of a trial free of charge for any member in the trial.
- Experimental or Investigational treatment not related to a Clinical Trial as defined above.

Compression Sleeves and Stockings

Coverage is provided for [two (2) pair of] compression sleeves and [two (2) pair of] compression stockings per Benefit Period.

Dental/Oral Surgery Services

Benefits for oral surgical procedures of the jaw or gums will be covered for:

- Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of symptomatic exostoses (bony growths) of the jaw and hard palate;
- Treatment of fractures and dislocations of the jaw and facial bones;
- Intraoral x-rays in connection with covered oral surgery; and
- General anesthetic for covered oral surgery.

Coverage is provided for diseases of the mouth, jaw and teeth related to radiation treatment, unless the condition is due to dental disease or of dental origin.

Limitations:

- Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:
 - The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and
 - The patient is:
 1. A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
 2. A person with a diagnosed serious mental or physical condition; or
 3. A person with a significant behavioral problem as determined by the Insured's physician.
 - If a person is Covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.
- Services relating to the acute trauma of sound, natural teeth caused directly by an accidental injury (not from biting or chewing) within a [six (6), twelve (12)] month consecutive period from the date of injury up to a maximum of \$1,000 of Allowed Amount(s). This benefit maximum does not apply to individuals under eighteen (18) years of age. A treatment plan must be submitted [within sixty (60) days of the injury] and approved by the Plan.

Exclusions:

- Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint).
- Dental x-rays, supplies and appliances including occlusal splints.
- Orthodontia and related services.

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- Oral surgery 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.
- Treatment of teeth or structures directly supporting the teeth, whether the services are considered to be medical or dental in nature except as specified above.

Dermatological Services

Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis

Coverage is provided 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 Services

Coverage includes Plan approved diabetic education classes, including self-management training used in connection with the treatment of diabetes; foot care, including medical or surgical treatment of onychomycosis (nail fungus); an annual diabetic retinal eye examination; and [one (1) pair of] orthopedic shoes and [two (2) pair] associated shoe inserts [per Benefit Period] for those individuals with demonstrated peripheral neuropathy.

Limitation:

Disposable insulin syringes, glucose meters, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under the medical benefit.

Dietician Counseling

Coverage [for up to four (4) visits per Benefit Period] is provided when rendered by a registered dietician.

Disposable Medical Supplies

Specific disposable medical supplies are covered when prescribed by Your Physician. Covered disposable supplies are limited to:

- Inhaler supplies (aero chamber masks, spacers and peak flow meters)
- Ostomy supplies (appliance pouches, skin care agents, support belts);
- Open wound supplies (gauze pads, wound packing strips, ABD pads);
- Supplies used in conjunction with covered Durable Medical Equipment (except for diabetic supplies);
- Tracheostomy supplies;
- Urinary supplies limited to catheters, bags and related supplies; and
- Venous access catheter supplies (alcohol pads, benzoin, OP site).

Durable Medical Equipment (DME)

DME is medical equipment 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 DME will be considered DME.

Coverage is provided 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.

Limitations:

- Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All

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maintenance and repairs that result from misuse are Your responsibility.

- Benefits are provided for one wheelchair or scooter and for repairs of that unit.

Exclusions:

- Electronically controlled heating and cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff);
- Home traction units;
- Preventive or routine maintenance due to normal wear and tear or negligence of items You own;
- Replacement for changes due to obesity; and
- Personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as a Covered Service.

Emergency Services

Coverage will be provided for Emergency Services if the symptoms You present and records by the attending Physician indicate that an Emergency Medical Condition exists; or for Emergency Services necessary to provide You with a medical examination and stabilizing treatment, regardless whether Prior Authorization was obtained to provide those services. Services provided by a Hospital emergency department for non-Emergency Medical Conditions are not covered.

[In situations where You require Emergency Services and have no control over when or where such services are rendered, You will not be responsible for the difference between the Provider's billed charges and Allowed Amount(s).]

Eye Glasses and Corrective Lenses

Coverage will be provided for the first pair of [eyeglasses or] corrective lenses following cataract or cornea transplant surgery [up to a maximum of \$150] or one (1) pair of contact lenses; or one (1) pair of sclera shells intended for use as corneal bandages or for medically-diagnosed eye diseases approved by Our Medical Director. [Benefits are limited to the amount available for a basic (standard) frame which meet the minimum specifications for the corrective lens(es), the cost of basic frames shall not exceed {\$100}.]

Family Planning

Covered Services are limited to:

- Office visits, medical evaluation, and counseling;
- Testing required to establish the etiology of male infertility, which is limited to sperm counts and/or semen analysis; scrotal ultrasound; prostate ultrasound, biopsy, and cystoscopy;
- Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal). Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider]; and
- [Sterilization procedures (vasectomy or tubal ligation).]

Exclusions:

- Fee associated with donors;
- Collection or storage of sperm;
- Those services related to conception through artificial means including, but not limited to, artificial insemination (IUI), in-vitro fertilization (IVF), gamete intrafallopian

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transfer (GIFT), zygote intrafallopian transfer (ZIFT) and similar procedures;

- Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and other testing, including those provided in any Physician's office setting;
- Embryo transplants;
- Reversal of voluntarily induced sterilization;
- Expenses of surrogate motherhood;
- Selective reduction;
- Any experimental procedure;
- Office visits, laboratory, x-ray and other testing associated with any Non-Covered Service;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal)]; and
- [Sterilization procedures (vasectomy or tubal ligation)]

[For maternity care coverage, reference the Maternity Care section of this document and Schedule of Benefits.]

Foot Care

Coverage for routine foot care provided by a Physician, including the paring and removing of corns and calluses or trimming of nails, will only be provided for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.

Exclusions:

- Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain.
- Medical or surgical treatment of onychomycosis (nail fungus) except persons with circulatory impairment or as described in the Diabetic Services section.

Genetic Studies

Coverage is provided for genetic counseling and tests only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Exclusions:

- Genetic testing when performed primarily for screening purposes.
- Genetic testing when performed primarily for purposes of embryonic pre-selection.

Hearing Screenings

Coverage is provided for a hearing screening to determine hearing loss.

Exclusion:

Services and associated expenses for the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests.

Home Health Care Services

Home health services will be provided as indicated in the Schedule of Benefits if You require skilled care and are homebound due to a disabling condition, are unable to receive medical care on an ambulatory outpatient basis, and do not require confinement in a Hospital or other Participating Facility. In order to receive the Network level of benefits, Home health services must be provided by an accredited Participating home health agency. Home health services include:

- Periodic and intermittent diagnostic and therapeutic services which can only be performed by professional nurses and other Participating Health Professionals if the services are ordered by a Physician; and

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- Consumable medical supplies and DME administered or used by such persons in the course of services rendered during such visits.

Limitations:

- Physical, occupational and speech therapy are subject to the benefit limitations and Copayments as described in the Rehabilitation Services section of this document and the Schedule of Benefits.
- Intravenous and injectable medications are subject to the benefits as described in the Therapeutic Injections and IV Infusions section of this document and the Schedule of Benefits.
- Home services to help meet personal, family, or domestic needs, including but not limited to eating, bathing, grooming, toileting, dressing, transferring or other custodial or self-care activities and private duty nursing, whether or not required by a Physician. This exclusion does not apply to wheelchairs, walkers, canes and crutches.

Hospice

Coverage is provided for hospice care rendered by a Provider for treatment of the terminally ill when ordered by a Physician. 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, including the services of a skilled nurse, physical or occupational therapist, home health aide, social worker, or chaplain; and guidance and assistance during the illness for the purpose of preparing You and Your family for a terminal illness.

Inpatient Hospital Care

Inpatient Hospital and Facility services will be covered for evaluation or treatment of conditions that cannot be adequately treated on an outpatient basis. Coverage includes Semi-private accommodations and associated professional and ancillary services. Certain services rendered during a Your confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits.

Exclusion:

Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable.

Mental Health and Substance Abuse

Covered benefits under this section are those specified in the most current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) or the Plan's utilization policies when more generous. Benefits under this section are only covered if such treatment is rendered by a licensed Provider who has the legal authority to diagnose and treat mental illness or substance abuse. [In order to receive the Network level of benefits, You should visit Your family Physician or a Participating Provider for outpatient treatment.] [You may also visit a Non-Participating Provider and receive the Non-Network level of benefits.]

Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, is subject to the applicable Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits. Outpatient treatment, including treatment through partial or full-Day Program Services, is subject to the applicable Deductible, Copayment and/or Coinsurance for services provided by Specialty Physicians as listed in the Schedule of Benefits. Medical services in conjunction with Mental Health or Substance Abuse treatment are subject to the applicable benefit defined on the Schedule of Benefits.

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Exclusion:

Mental illness and/or chemical dependency services for the following: 1) services utilizing methadone treatment as maintenance, LAAM (1-Alpha-Acetyl-Methadol), cyclazocine, or their equivalent; except where methadone or its equivalent is used as medically prescribed treatment in a federally approved detoxification program for drug abuse; and 2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

Orthotic Appliances

Orthotic appliances correct or support a defect of a body form or function. Coverage is provided for the purchase of orthotic appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for orthotic appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if You have diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.

Exclusions:

- The replacement costs for any otherwise Covered appliance for changes due to obesity;
- Routine maintenance due to normal wear and tear or negligence of items You own;
- Foot or shoe inserts, arch pads, or insoles whether custom-made or prefabricated;
- Cranial (head) remodeling bands or any such service or supply for the treatment of positional non-synostotic plagiocephaly and other protective head gear.

Outpatient and Physician Office Services

Coverage will be provided for those services requested or directed by the Plan or a Physician to be provided on an outpatient basis, including:

- Diagnostic and/or treatment services.
- Lab services.
- Diagnostic and therapeutic radiology services.
- Health evaluations.
- Administered drugs, medications, biologicals, and fluids which have been approved by the FDA, have a National Drug Code, and are administered under the supervision of a Physician.
- Services which can be appropriately provided on an outpatient basis such as certain surgical procedures, which can include anesthesia, recovery room services, ambulatory surgical centers and Hospital outpatient surgical centers.
- Physician services, including office visits, Hospital visits, consultations, and interpretation of tests.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.
- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Origination site fees and technical component fees associated with telehealth.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food

Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.

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Limitation:

Enteral pumps and supplies will be covered only when the above criteria are met.

Exclusion:

The cost of outpatient Enteral tube feedings or formula and supplies are not covered except when used for PKU or any other amino and organic acid inherited disease, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition.

Preventive Services

If received from a Participating Provider, Coverage for the following services will be provided at in a manner consistent with Section 2713 of Federal H.R. 3590. Coverage for these services will be provided once annually, unless otherwise specified below:

- Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention (ACIP-CDC);
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings for women (including breast cancer screening and mammography screenings) not described in #1.

A complete list of the covered preventive services, including any age limitations, is available on Our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Services number on Your ID card.

Please note:

- A preventive care service is designed to prevent or detect an illness, disease, or condition before the occurrence of the condition. This can include office visits, patient education, immunizations, and diagnostic testing. Preventive care services are performed before a disease is diagnosed and in the absence of symptoms. Services that are related to or in follow-up of an established illness, disease, condition and/or for a symptom are not part of a preventive care service.
- If a covered preventive service is provided during an office visit, it must either be billed separately from the office visit or be the primary purpose of the office visit in order to be covered under this benefit. If the preventive service is not billed separately and the primary purpose of the visit is not to provide the preventive service, then the applicable Copayments, Coinsurance and/or Deductible will apply to the office visit.

[In order to receive the Network level of benefits, You should visit Your family Physician or a Participating OB/GYN specialist for the annual well-woman exam or may visit a Participating urologist for the annual well-man exam. You may also visit another provider and receive the Non-Network level of benefits.]

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.

COVERED SERVICES

- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Costs associated with immunizations for travel.

Prosthetic Devices

Prosthetic devices aid body functioning or replace a limb or body part and can be either internally or externally placed. Coverage is provided for the purchase of prosthetic devices following the onset or initial diagnosis of the condition for which the device is required. For prosthetic device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for prosthetic devices, including but not limited to, purchase of artificial limbs, bone anchored hearing aids, breasts, cochlear implants, 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. Coverage is provided for external prosthetic devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Coverage will be provided for replacement of prosthetic devices, which become non-functional and non-repairable due to: (1) A change in Your physiological condition; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a Dependent child requiring replacement.

Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.

Exclusions:

- Those repairs or replacement costs for any otherwise Covered device, including replacement for changes due to obesity.
- Routine maintenance due to normal wear and tear or negligence of items You own.
- Electronic or computerized prosthetic limbs.
- Eyeglasses and contact lenses, except as described as a Covered Service.
- Hearing aids, except as above; digital and programmable hearing devices; hair pieces, prosthesis and styling; dental plates, bridges, braces, or any dental prostheses.

Reconstructive Surgery

Reconstructive procedures are those services that are performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Procedures and services which are related to psychological consequences or socially avoidant behavior as a result of injury, illness or congenital or developmental anomaly do not classify surgery or other procedures as a reconstructive procedure.

Coverage is provided for reconstructive treatment or surgery only under the following circumstances:

- Correction or repair of an accidental injury even if a cosmetic effect occurs.
- Correction or repair of a body part to improve/restore impairments of bodily function resulting from disease, trauma, or previous therapeutic processes.
- Correction or repair of congenital abnormalities and hereditary complications or conditions are limited to:
 - Improving/restoring impairments of bodily function such as cleft lip or palate;

COVERED SERVICES

- Birthmarks on head or neck;
- Webbed fingers or toes; and
- Supernumerary digits or toes.
- Removal of leaking breast implants, not including implant replacement.
- Services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service and will be provided in a manner determined in consultation with You and the treating Physician including:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses and physical complications from all stages of the mastectomy, including lymphedema; and
 - Two (2) bras per Benefit Period will also be covered following the mastectomy if purchased from a Participating Provider.

Exclusions:

- Elective or voluntary enhancement procedures, services, or medications for sexual performance, athletic performance, cosmetic purposes, anti-aging, or mental performance including, but not limited to: Botox, Restylane, growth hormone, testosterone, hair removal or hair transplant.
- Cosmetic therapies or surgical procedures primarily to restore or alter the appearance including, but not limited to: surgical excision or reformation of any sagging skin on any part of the body such as eyelids, face, neck, abdomen, arms, legs or buttocks; alabrasion; chemosurgery; laser surgery or other skin abrasion procedures related to removal of scars, tattoos, or actinic/acne changes.
- Services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body such as breasts, face, lips, jaw, chin, nose, ears or genitals (i.e. labia reduction).
- Treatment of gynecomastia.

Rehabilitation Services and Supplies

Rehabilitative services are designed to restore normal physical functions following injuries, surgeries, or acute medical conditions and are Covered when they are expected to resulting significant improvement in the patient's condition.

Services include physical, occupational, speech therapies, spinal manipulations, and cardiac and pulmonary rehabilitation. Authorization or referral may be required, please review the Prior Authorization list at the end of this document.

Spinal manipulation services are covered for the manual treatment used to influence joint and neurophysiological function.

Limitation:

Rehabilitation services are covered only if they are expected to result in significant improvement in Your condition. The Plan will determine whether significant improvement has, or is likely to occur based on the medical information received from Your Physician.

Exclusions:

- Therapy in which the goal is maintenance, rather than significant improvement.
- Convalescent or custodial care.

COVERED SERVICES

- Vocational rehabilitation including, but not limited to, employment counseling and training.
- Cognitive therapy including, but not limited to: behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and/or mental retardation testing and treatment.
- Developmental therapy, unless a congenital condition is the underlying cause for the delay.
- Athletic evaluation and training.
- Services that federal or state laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).
- Speech therapy or voice training when prescribed for stuttering or hoarseness.
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column.

Therapeutic Injections and IV Infusions

Therapeutic injections and IV infusions are those prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the individual. Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.

[Intravenous and Injectable anti-cancer (chemotherapy) drugs will be covered as indicated on the Schedule of Benefits.]

Limitation:

Growth hormone therapy is only covered for those individuals under 18 years of age who meet the criteria for Coverage and who have been appropriately diagnosed with a growth hormone deficiency or pituitary disorder according to clinical guidelines used by the Plan.

Exclusions:

- Any drug, medicine or medication prescribed in doses exceeding the manufacturer-recommended maximum dose documented in the package insert that is approved by the FDA. This exclusion shall not apply to a drug, medicine or medication dose that is referenced in one of the standard reference compendia or in generally accepted peer-reviewed medical literature.
- Self-Injectable Prescription Drugs are drugs that are commonly and customarily administered by the individual according to clinical guidelines used by the Plan. Any Self-Injectable medication that is covered by a pharmacy Rider is excluded from the medical benefit.

Transplants

Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Designated Transplant Network Facility and You are the recipient.

[Donor screening tests are Covered when performed at a Designated Transplant Network Facility.]

If not Covered by any other source, the cost of any care, including complications up to 90 days, arising from an organ donation by a non-participant when You are the recipient will be Covered for the duration of Your Policy when approved by the Plan.]

COVERED SERVICES

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

[If You reside more than {one hundred-fifty (150)} miles from the transplant facility, reimbursement for travel will be Covered.] [Travel expenses may include the lodging for You and a companion.] Lodging and meal costs incurred by You and a companion [is Covered in accordance with the Plan's utilization policy and procedure.][for a period beginning twenty-four (24) hours prior to admission for the transplant procedure and forty-eight (48) hours after Your discharge are also covered. Lodging and meal costs are subject to a \$125 per day limitation. Transportation, lodging and meal costs shall not exceed a maximum benefit of {\$2,000} per transplant.]

Exclusions:

- Any associated expenses, including complications, arising from an organ donation when You are the donor [and the recipient is not Covered under the Plan].
- Any associated expenses involving temporary or permanent mechanical or animal organs.
- Reimbursement for organ harvesting.

Urgent Care Services

A condition that requires urgent care is an unexpected illness or injury that is not life-threatening but requires prompt medical attention. Examples of urgent care conditions include sprains, lacerations and severe abdominal pain.

Vision Services

Coverage is provided for eye examination including medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.

Exclusions:

- Corrective contact lens fitting.
- Surgical treatment for the correction of a refractive error, including but not limited to: radial keratotomy, LASIK, or refractive lensectomy with intraocular lens implant.
- Other vision care services, including but not limited to: visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
- [Vision hardware (i.e. frames) unless covered under a Vision Rider.]

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[Pre-Existing Conditions Limitation]

[Pre-Existing Conditions may affect Your premium rate, may result in denial of Your application, or We may deny Coverage for them for a period of time after Your effective date. If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-Existing Condition that You disclosed on Your enrollment form, and such conditions will be Covered under the terms of Your Policy beginning on Your effective date. Any Pre-Existing Condition(s) that is not disclosed on Your enrollment form will be excluded from Coverage for a period not longer than twelve (12) months after Your effective date.

Pre-Existing Condition Exclusions shall not apply to any Covered Person under the age of 19.]

The following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Policy.
- Any service or supply that is not Medically Necessary.
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service and subsequent complications which may occur.
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational.
- Court-ordered services including forensic or custodial evaluations; evaluations and diagnostic tests ordered or requested in connection with criminal or legal actions; damages in any kind of personal injury action, divorce, child custody, paternity, severance of parental rights, or child visitation proceedings; or services that are a condition of probation, parole or diversion agreements.
- Those services otherwise Covered under the Policy related to a specific condition when You have refused to comply with, or have terminated the scheduled service or treatment against the advice of a Provider or the Mental Health/Substance Abuse Designee.
- Those services otherwise Covered under the Policy, but rendered after the date Coverage under the Policy terminates, including services for medical conditions arising prior to the date individual Coverage under the Policy terminates.
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as You, or rendered by a person who is a member of Your family, including spouse, brother, sister, parent, stepparent, child or step-child.
- Any portion of a Claim that the Plan determines to be incorrectly or inappropriately billed by a Physician, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

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

Abortion

Services related to elective abortions unless covered under an attached Rider. An elective abortion is a termination of pregnancy for any reason other than a spontaneous abortion (miscarriage) or to prevent the death of the individual upon whom the abortion is being performed.

Alternative Therapies

All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupuncture, acupressure, hydro-massage, hypnotherapy, hypnosis, massage therapy, Vax-D therapy, reflexology, cranio-sacral therapy, and therapy for the

EXCLUSIONS

	development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
Apparel	Items of wearing apparel including, but not limited to TENS unit sleeves, except as specified in the Covered Services section.
Augmentative Communication Devices	Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled individuals.
Autopsy	Those services and associated expenses related to the performance of autopsies, unless requested by the Plan, to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan.
[Biofeedback	Any expenses related to biofeedback.]
Chelation Therapy	Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
Counseling	Expenses related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
Custodial Care	Domiciliary care, convalescent care, residential care, respite care or rest care. This includes care that assists You 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 whether or not required by a Physician.
Duplicate Benefits	Benefits of this document will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This document will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services.
Eligible Expenses	Any otherwise eligible expenses that exceed the maximum allowance or benefit limit.
Food	Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for in the Covered Services Section.
Foreign travel	Care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services.
Fraud	Any service(s) rendered and/or billed by a Provider through misrepresentation of material fact or intentional fraud.
Halfway House	Services rendered or billed by a school or halfway house.
Hair analysis	Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.

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Health Club Membership	Any costs of enrollment in a health, athletic or similar club.
Household Equipment and Fixtures	Purchase or rental of household equipment including, but not limited to: fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hot tubs, hypo-allergenic pillows, pools, power assist chairs, mattresses or waterbeds, car seats, strollers, shower chairs, commodes, breast pumps, bedwetting alarms, prenatal cradles, electronic communication devices, braces and supports needed for employment, and modifications to Your home or vehicle.
Illegal Acts	Injuries incurred while You are in the commission or attempted commission of a felony, except when the injury is the result of You being a victim of domestic violence.
Immunizations	Those immunizations for travel, employment or education unless otherwise Covered under the Covered Services Section.
Maternity Services	Expenses incurred for any condition of or related to pregnancy, including childbirth, routine pregnancy visits, nursery care charges, and delivery whether by vaginal or Cesarean birth, or selective reduction. Complications due to or developed during pregnancy are Covered like any other illness.
Medical-Legal	Services rendered primarily for the purpose of medical-legal reasons including, but not limited to, a Provider/patient contract to determine and monitor compliance with prescribed drug treatment, or for the purpose of Provider malpractice protection, that lack medical necessity as defined by this document. This does not include monitoring for therapeutic medication levels, which are deemed Medically Necessary.
Military Health Services	Those services for treatment of military service-related disabilities when You are legally entitled to other Coverage and for which facilities are reasonably available to You; or those services for any otherwise eligible individual or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act.
Miscellaneous Service Charges	Miscellaneous service charges including, but not limited to, consultations performed through use of telephone, fax, or email communication; case management team conferences; consultations with family members; charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service); or any late payment charge.
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.
Non-Medical Ancillary Services	Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, educational testing, training, or therapy,

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	unless approved by the Plan as part of treatment for traumatic head injury or stroke, or as specified in the Covered Services section.
Non-Prescription Drugs and Medications	Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional Pharmacy Rider.
Nutritional-Based Therapy	Nutritional-based therapies except for treatment of 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 regardless of whether it is the sole source of nutrition except as provided for under PKU or any other Amino and Organic Acid Inherited Disease Food/Formula.
Nutritional Supplements	Vitamins, minerals, nutritional supplements, medical foods, breast milk and formulas, or special diet foods whether or not required by a Physician except as required to be covered by law.
Obesity Services	Those 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, jejuna bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.
Over-the-Counter Supplies	ACE wraps, batteries, elastic supports, finger splints, orthotics, and braces; also over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, therabands, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider.
Pain Management	Costs associated with commercial pain management programs.
Personal Comfort and Convenience	Services or items for the Provider's or Your convenience including items or services such as home laboratory testing, television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Prescription Drugs and Medications	Prescription and non-prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider to the Policy.
Private Duty Nursing	Private duty nursing services, whether or not required by a Physician; nursing care on a full-time basis in Your home; or home health aides.
Rebating	Any service(s) rendered where You receive monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).

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Replacement Items	Costs associated with the replacement of items that are damaged, lost, or stolen.
Sex Transformation Services	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.
Sexual Dysfunction	Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia.
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 including braces, supports and orthotics.
TMJ and MPDS	Services related to the diagnosis and treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) unless covered by an attached Rider.
Third Party Liability	Services for which a third party has liability (by whatever terminology used-including such benefits mandated by law).
[Tobacco Cessation	Those services and supplies for tobacco cessation programs and treatment of nicotine addiction.]
Travel or Transportation Expenses	Transportation, food, and lodging expenses even though prescribed by a Participating Provider, except as specified in the Covered Services Section.
War or act of war	Services received as a result of war or any act of war when You are outside of the continental United States, whether declared or undeclared or caused during service in the armed forces of any country.
Workers compensation	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 program.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility

Medical Underwriting

Eligibility for Coverage under this Policy is based on health-related factors, excluding genetic testing. An evaluation of the applicant's medical history will determine acceptance and final Premium for this Coverage.

- In order to determine acceptance the Plan will review the Medical Questionnaire information from the Enrollment Form.
- If minor clarification is needed the Plan will send an additional questionnaire and ask You to complete the form.
- If more detailed information is needed additional medical information may be requested from the Provider listed on the Enrollment Form Medical Questionnaire or additional information provided by You.
- If we have not received the information requested within thirty (30) days, the application will be deemed denied.

Policyholder

To be eligible as a Policyholder, You must:

- Live [or work] in the Service Area during the entire Year unless on temporary work assignment of six (6) months or less;
- Pay required premiums when due; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

Dependents

To be eligible to be enrolled under this Policy as a Dependent, an individual must:

- Be the lawful spouse of the Policyholder or be a child of the Policyholder or the Policyholder's spouse including:
 - Children up to their twenty-sixth (26) birthday who are either the birth children of the Policyholder or the Policyholder's spouse or legally adopted by or placed for adoption with the Policyholder or Policyholder's spouse;
 - Children up to their twenty-sixth (26) birthday for whom the Policyholder or the Policyholder's spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
 - Children up to their twenty-sixth (26) birthday for whom the Policyholder or the Policyholder's spouse is the court-appointed legal guardian;
 - Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Policy Holder or the Policy Holder's Spouse 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 Insured upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

A spouse must live in the Plan's Service Area at least [six (6), nine (9)] months out of the year. [Notwithstanding the above, a common law spouse qualifies as a spouse under this Policy only if his or her spousal status is affirmed by a court of competent jurisdiction.]

Enrollment

Persons Not Eligible to Enroll

- A person who fails to meet the eligibility requirements specified in this Policy shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Policy.

- A person whose Coverage was terminated due to a violation of a material provision of this Policy shall not be eligible to enroll with the Plan for Coverage under this Policy.
- A person who is on active duty in the armed forces of any country shall not be eligible to enroll.
- Except as otherwise specifically stated in the Policy or as required by law, initial enrollment is limited to individuals who are not eligible for Title XVIII of the Social Security Act 49 Stat. 620 (1935), 42 USCA 301 as amended (Medicare) or any similar program sponsored by the federal government or a state government.

Special Enrollment

New Spouse Due to Marriage. Subject to the Medical Underwriting provisions noted above, the Policy Holder's new Spouse may enroll at any time after marriage.

New Dependents Due to Birth. New Dependents Due to Birth. A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

New Dependents Due to Adoption. A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

Notification of Change in Status

A Covered individual 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 Covered individual.

TERMINATION OF COVERAGE

Termination of Coverage	This Policy shall be renewable at Your option, except as described immediately below. Non-renewal shall not be based upon the deterioration of mental or physical health of the individual under this Policy. Your Coverage shall terminate if any one of the following events occurs:
<i>Loss of Eligibility</i>	If You no longer meet the eligibility requirements set forth in this Policy, Your coverage shall end at 11:59 p.m. on the date You no longer meet the eligibility requirements.
<i>Non-Payment</i>	You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the ten (10) day grace period, You will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the ten (10) day grace period.
<i>Change in Status</i>	You change Your place of residence outside our Service Area.
<i>Non-Compliance</i>	Coverage under this Policy may be canceled, Reformed or Rescinded based on medical or other enrollment or eligibility information received which was not properly or completely disclosed, or was falsely disclosed in Your Application agreement, prior to contracting or enrollment. NOTE: If Your Coverage is Rescinded, as described in this section, Coverage will be termed back to the effective date and the Plan will seek recovery of all payments made on Your behalf. Therefore, both You and the Plan will be returned to a financial position as if no Coverage had ever been in force. The Plan may initiate this action in the event that, among other possible reasons, there is a Material Misrepresentation that led the Plan to provide coverage. However, Your Coverage will not be Rescinded due to improper disclosure on the Application agreement after coverage has been in effect for two (2) years. This exception does not apply in the case of fraudulent misrepresentation.
<i>Misrepresentation</i>	You participate in fraudulent or criminal behavior, including but not limited to: <ul style="list-style-type: none">▪ Performing an act or practice that constitutes fraud or Material Misrepresentation of facts including, but not limited to using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled.▪ Allowing any other person to use Your identification card to obtain services. If You allow any other person to use Your identification card to obtain services, Your Coverage will be terminated.▪ Knowingly misrepresenting, omitting or giving false information on any Policy forms and medical questionnaire.
<i>Criminal Behavior</i>	You participate in criminal behavior, including but not limited to 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 Policyholder and all Dependents will be terminated.
Effect of Termination	If Your Coverage under this Policy is terminated, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination. Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

TERMINATION OF COVERAGE

Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Claims and Appeals procedures. The Plan may not terminate the Policy solely for the purpose of effecting Your disenrollment for either of these reasons.

If You receive Covered Services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

Upon the death of an insured, premiums paid for Coverage for the insured for any period beyond the end of the policy month in which the death occurred shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the insurer.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Policy, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. If the Plan elects to discontinue offering all health insurance coverage in the individual 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. Termination of the Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the Policy.

Certificates of Creditable Coverage

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

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules listed below determine which plan will pay as the primary plan. The primary plan 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.

COB Definitions

Plan

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 participants 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 \$200 per day; school accident-type coverage; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
- "Plan" does not include: group or group-type accident only coverage; individual or family insurance; closed panel or other individual coverage; amounts of hospital indemnity insurance of \$200 or less per day; 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 is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.
- The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
- When this plan is primary, its benefits are determined before those on any other plan and without considering any of the other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

Allowable Expense

A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example a 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 allowable expenses:

- If a covered person 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 Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
- If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one plan calculates its benefits or services on the basis of usual and customary fees and the other plan provides its benefits or services on the basis of negotiated fees, any amount in the excess of the highest of

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the fees is not an allowable expense.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider organizations.

Claim Determination Period

A calendar year; however, it does not include any part of a year during which the participant has no Coverage under this plan or before the date this COB provision or similar provision takes effect.

Closed Panel Plan

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 the case of emergency or referral by a panel member.

Custodial Parent

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.

ADEA Employer

An employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA), and has twenty (20) or more Employees each working day in twenty (20) or more calendar weeks during the current or preceding Benefit Period.

Medicare Benefits

Benefits for services and supplies which You receive or are entitled to receive under Medicare Parts A or B.

Order of Benefit Determination Rules

When two (2) 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 regulation 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 basic package of benefits provided by a 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 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.
 - **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, (e.g. as an Employee, Participant, Subscriber or Retiree) is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person 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 person as an Employee, Participant or Subscriber, or Retiree is secondary and the other plan is primary.
 - **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
 - o The primary plan is the plan of the parent whose birthday is earlier in the year if:

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- the parents are married;
 - the parents are not separated (whether or not they ever have been married); or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
- o 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. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. This rule applies to Claim determination periods or plan years commencing after the plan is given notice of the court decree.
- o 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:
- the plan of the custodial parent;
 - the plan of the spouse of the custodial parent;
 - the plan of the non-custodial parent; and then
 - the plan of the spouse of the non-custodial parent.
- **Active or Inactive Employee.** The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person 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. Coverage provided to an individual as a retired worker or as a Dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.
- **Continuation Coverage.** If a person 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 person as an Employee, Participant or Subscriber, or Retiree (or as that person'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.
- **Longer or Shorter Length of Coverage.** The plan that covered the person as an Employee, Participant, Subscriber or Retiree longer is primary.
- 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.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits on a Claim so that the total benefits paid or provided by all plans are not more than 100% of the total allowable expenses. The difference between the benefit payments that this plan would have paid had this 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, this plan will:

- Determine its obligation to pay or provide benefits under its contract.

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- Determine whether a benefit reserve has been recorded.
- Determine whether there are any unpaid allowable expenses.
- The benefits of the secondary plan will be reduced, so that they and the benefits payable under the other plans do not total more than 100% of the allowable expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and is charged against any applicable benefit limits or maximums. This plan will not pay more as secondary than it would have paid had it been primary.

If a covered person is enrolled in two (2) 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 the other closed panel plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

This Provision applies when You have Coverage under this document and are eligible for hospital insurance under Medicare Part A (whether or not You have applied or are enrolled for Medicare Benefits.) This Provision applies before any other COB provision of the policy.

If, in accordance with the following rules, the Plan has primary responsibility for Your Claims, then the Plan pays benefits first. If, in accordance with the following rules, the Plan has secondary responsibility for Your Claims; first Medicare benefits are determined or paid and then the Plan's benefits are paid. However, for services payable under both plans the combined Medicare Benefits and the Plan's benefits will not exceed 100% of total allowable expenses.

Rules for Determining Order of Benefits

Subscriber: We have primary responsibility for Claims if the Subscriber is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer

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who pays all or part of the Agreement's premium. We have secondary responsibility for Claims when a Subscriber is eligible for Medicare Part A or B, and is not actively employed by an ADEA employer who pays all or part of the Group Contract's premium.

Dependent: We have primary responsibility for a Dependent's Claim if the Dependent is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for a Dependent's Claims when he or she is eligible for Medicare Part A or B, and the Subscriber is not actively employed by an ADEA employer who pays all or part of the Agreement's premium.

Persons with End-Stage Renal Disease: We have primary responsibility for the Claims for You for up to thirty (30) months from the date You begin a regular course of renal dialysis or You could be entitled to Medicare after receiving a kidney transplant. Medicare benefits are secondary only for that portion of the thirty (30) month period remaining after You become eligible for Medicare. Thereafter, Medicare benefits are primary, and the Plan's benefits are secondary.

Persons under Non-ADEA employer plans: We have secondary responsibility for Your Claims if the employer under the Agreement is not an ADEA employer.

CLAIMS AND APPEAL PROCEDURES

You may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, You or Your Authorized Representative may call or write the Plan to file a complaint or an appeal. We will provide You a full and fair review of Claims decisions and Appeal decisions as required under ERISA. If You receive Your health benefits coverage through any arrangement that is not subject to ERISA, You have the same Claims and Appeal rights as a matter of contract. Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Policy.

Definitions

Administrative Appeal

For the purposes of this section, the following terms and their definitions will apply:

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

Adverse Benefit Determination

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services;
- The failure, reduction, or termination regarding terms of the contractual relationship between You and the Plan; and/or
- Rescission of coverage.

Appeal

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

Claim for Benefits or Claim(s)

A request for a service or payment of a service You make in accordance with the Plan's procedure for filing Claims. A Claim includes urgent care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this document.

Claim Eligible for External Review

(1) In the case other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which You have received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, or (2) in case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Plan that a proposed health care service, which would otherwise be covered under this Certificate, is not Medically Necessary or the health care treatment has been determined by the Plan to be Experimental or Investigational and the denial would leave You with a financial obligation or prevent You from receiving the requested service.

Complaint

Any dissatisfaction expressed by You or Your Authorized Representative regarding a

CLAIMS AND APPEAL PROCEDURES

	Plan issue.
<i>Expedited Appeal</i>	An Appeal that may be requested either orally or in writing if You feel Your condition requires urgent care.
<i>External Review</i>	The review of an Adverse Decision by an external review organization, which conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Department of Insurance.
<i>Inquiry</i>	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.
<i>Medical Necessity Appeal</i>	An Appeal of a determination by the Plan or its designated 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
<i>Post-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
<i>Pre-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization. Routine inquiries about Coverage information do not constitute Pre-Service Claims.
<i>Urgent Care</i>	Care for a condition when a delay in receiving such care could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your condition, would subject You to severe pain that could not be adequately managed without care or treatment that is the subject of the Claim. In determining whether a Claim involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of Your medical condition determines a Claim involves urgent care, the Claim must be treated as an Urgent Care Claim.
<i>Urgent Care Appeal</i>	An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of You or Your unborn child; or (b) Your ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
<i>Urgent Care Claim</i>	A request for a Claims decision regarding urgent care.
Complaints	<p>A Complaint is a verbal expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.</p> <p>Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, You will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days</p>

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thereafter. You will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than You, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

[P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343]

Process for Submitting an Appeal

You or Your Authorized Representative has the right to obtain, without charge, copies of the documents, relating to the Adverse Decision, including the name of the utilization review organization used to review the Claim and may Appeal an Adverse Decision from an initial Claims decision by:

- submitting the Appeal in writing to [8320 Ward Parkway, Kansas City, MO 64114] to the attention of the appeals committee;
- sending a fax to [816-769-2408]; or
- [sending an e-mail to] [KCCCompliance@cvty.com].

If You believe Your health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, You may make an oral request for an Expedited Appeal by calling the Customer Service Department at the number on Your ID card.

Appeals should include:

- Your name and ID number.
- Specific information relating to and reason for the Appeal.
- Your expectation for resolution.
- Copies of medical records or other documentation that You wish to be considered in the Appeal.

The appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, You may be referred for a second opinion.

Appeal of Adverse Decisions

A decision on the Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date of the receipt of notification of the initial Adverse Decision)	180 days	180 days	180 days
Appeal Decision (from the date the Appeal is received by the Plan)	36 hours	15 days	20 working days

You may voluntarily agree to provide the Plan additional time within which to make a decision.

In the case of an Urgent Care Appeal, You and/or Your Authorized Representative will

CLAIMS AND APPEAL PROCEDURES

be notified verbally and will be provided a follow-up written notice within 36 hours of receipt of the Appeal request.

You will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than You, who submitted the Appeal will be notified.

Procedure for Pursuing an External Review

You have the right to request an External Review after a final Adverse Decision has been rendered, or when You have not received a final Adverse Decision within sixty (60) days of seeking such review, unless the delay was requested by You for eligible Claims as defined in the Claims Eligible for External Review section. We will notify You in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

Within one-hundred twenty (120) days of receipt of the notice of the final Adverse Decision, You, the treating Provider acting on Your behalf with written authorization from You, or Your legally authorized designee, must make a written request for an External Review to [Us] [the Arkansas Insurance Department].

The right to External Review shall not be construed to change the terms of Coverage under this document. In no event shall more than one (1) External Review be available during the same year for any request arising out of the same set of facts.

You may contact the State Insurance Department at anytime by mail or telephone:

- Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

UTILIZATION REVIEW POLICY AND PROCEDURES

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 Skilled Nursing Facility, 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 Prior Authorized by the Plan, after the services have been provided.

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.

Timing of Utilization Review Decisions

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

Prospective or Pre-Service Review

Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide You and the Provider written or electronic confirmation of the telephone notification within two (2) working days of making the initial certification.

Concurrent Care Review

Determination regarding an extended stay or additional services will be made within one (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to You until You have been notified of the determination. The Plan shall notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide You and the Provider written or electronic confirmation within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

Retrospective or Post-Service Review

Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide You written notice of determination within ten (10) working days of making the determination.

Notification

In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the Provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide You and the Provider written or electronic notification within one (1) working day of the telephone notification.

UTILIZATION REVIEW POLICY AND PROCEDURES

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.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

Right to Appeal

You also have the right to an expedited or standard Appeal. Please see the Claims and Appeal Procedures Section of this document for the time frames for Appeals. Reconsideration is not a prerequisite to any Appeal.

Denial of Claims

The Plan's Medical Director shall make decisions regarding the denial of Coverage when related to Medical Necessity. Notices of claim denials shall include information regarding the basis of the decision and further Appeal rights.

Technology Assessment

The Plan uses a technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including but not limited to, medical procedures, drugs and drug therapies, and devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical databases, specialty medical societies, applicable government publications, the Plan Medical Directors, Pharmacy Department, and specialists, researchers, or institutions that specialize in the condition involved as needed.

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

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

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

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

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

UTILIZATION REVIEW POLICY AND PROCEDURES

[Case Management

Case management is a program conducted by the Plan that:

- Identifies cases involving a patient in a clinical situation that presents either the potential for catastrophic Claims or a utilization pattern that exceeds the norm.
- Assesses the appropriateness of the level of patient care and the setting in which it is received.
- Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care through discussion and Policy with You or Your legal representative, Provider(s), and the Plan.

This treatment plan may include both Covered Services and Non-Covered Services. Payment of benefits for such services or supplies shall be subject to the terms and provisions of this document.]

GENERAL PROVISIONS

Applicability	The provisions of this Policy shall apply equally to the Policyholder and Dependents and all the benefits and provisions made available to You shall be available to Your Dependents.
Governing Law	This Plan is delivered and governed by the laws of the State of Arkansas.
Limitation of Action	You must exhaust the Plan's Claims and Appeals Procedure prior to pursuing legal action, (in a court or other government tribunal). No action at law or in equity shall be brought to recover under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Plan. 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.
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 Policy. Such right to health care service Coverage or other benefits is not transferable.
Relationship Among Parties Affected by Policy	<p>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.</p> <p>You are not an agent or representative of the Plan, and neither shall You be liable for any acts or omissions of the Plan for the performance of services under this Policy.</p>
Reservations and Alternatives	The Plan reserves 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 You. You must cooperate with those persons or entities in the performance of their responsibilities.
Severability	In the event that any provision of this Policy is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Policy, which shall continue in full force and effect in accordance with its remaining terms.
Valid Amendment	No change in this Policy shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Policy and/or by Amendment to this Policy. Such Amendments will be incorporated into this document. Amendments to this document are effective upon thirty-one (31) days written notice to You. No change will be made to this document unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change this document or to waive any of its provisions.
Waiver	The failure of the Plan or You to enforce any provision of this Policy 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 Policy shall

GENERAL PROVISIONS

not be deemed or construed to be a waiver of such default.

Entire Policy

This Policy shall constitute the entire Policy between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Policy that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Your Coverage shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, or unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

Notwithstanding the Schedule of Benefits in this Plan, the Plan may provide different benefits to different individuals, as determined by the Plan and applicable individuals. Such differences in benefits shall be allowed only as the result of a written Amendment to the Policy or a written Rider or similar document, approved by the Plan.

Participation in the Policies of the Plan

If You wish to participate in matters of the Plan's policies and operations, You may do so by submitting suggestions, in writing, to the Customer Service Department at the address located in the Schedule of Important Numbers. The Plan's Quality Improvement Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body.

Records

You 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 document in the event the Plan is unable to obtain this information directly from the Provider or insurer.

By accepting Coverage under this document, each individual, including enrolled Dependents, whether or not such enrolled Dependents have signed the application of the Policyholder, authorizes and directs any person or institution that has provided services to You, 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 You. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of this document or for appropriate medical review or quality assessment.

Examination

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine You at the Plan's expense.

Clerical Error

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

Notice

Written notice given by the Plan is deemed notice to all affected Policyholders and their enrolled Dependents in the administration of Coverage under this document, including termination of Coverage.

GENERAL PROVISIONS

Workers' Compensation	The Coverage provided under this document does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.
Conformity with Statutes	Any provision of this document 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.
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, genetic information, or public assistance status.
Provisions Relating to Medicaid Eligibility	<p>Payment for benefits will be made in accordance with assignment of rights made by You or on Your behalf, 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 services, the Plan will pay for such services in accordance with any State law, provided that the State has acquired such rights to payment.</p> <p>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.</p>
Policies and Procedures	The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Policy.
Discretionary Authority	The Plan has the discretionary authority to interpret the Policy 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 Policy. In no way shall this section limit any of Your rights as set forth in the Claims and Appeals section or any rights permitted under law.
Value Added Services	From time to time the Plan may offer to provide You 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 You 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 You 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.
Applications and Statements	You shall complete and submit to the Plan such applications, or other forms or statements, as the Plan may reasonably request. The only statements You make that may be used in any legal action concerning this document issued hereunder are statements that are in writing. Any such written statement will be considered a representation and not a warranty.
Cooperation with Claims	You shall cooperate with the Plan in the benefit determination process and regarding

GENERAL PROVISIONS

Investigation

the investigation of Claims relating to Covered Services, Coordination of Benefits, Medical Necessity determinations, utilization review and fraud and abuse functions. This duty to cooperate includes, but is not limited to, providing upon request by the Plan a written statement and/or testimony under oath regarding any Claim where Your name, identification or identity is utilized. Failure to cooperate may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Federal and State Law Requirements

You shall provide the Plan with any information that is required for Us to comply with federal or state law requirements. Failure to provide the required information may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Time Limit on Certain Defenses

Except for fraud, no statement shall be used to deny Your Claim after two (2) years. The two (2) years start from the date of Your application for submission of evidence for reinstatement.

GLOSSARY

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

Activities of Daily Living	Activities You usually do during a normal day including but not limited to bathing, dressing, eating, grooming, maintaining continence, toileting, transferring, and mobility.
Allowed Amount(s)	The maximum monetary amount the Plan calculates for Covered Services, either in accordance with the Participating Provider's contract or the Non-Participating Provider Fee Schedule, when rendered to individuals and/or authorized by the Plan.
Alternate Facility	<p>A duly-licensed 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:</p> <ul style="list-style-type: none">▪ Scheduled surgical services;▪ Emergency services;▪ Urgent Care Services;▪ Prescheduled rehabilitative services;▪ Laboratory or diagnostic services;▪ Inpatient or outpatient Mental Illness services or Substance Abuse services.
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.
Amendment or Endorsement	Any attached written description of additional or alternative provisions to the Policy and/or this document. Amendments or Endorsements are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.
Ancillary Provider	A Provider who is not licensed as a Physician or a Hospital.
Authorized Representative	An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for HIPAA privacy purposes.
[Basic Health Services	Services which You may reasonably require in order to be maintained in good health, including as a minimum, inpatient Hospital, Physician, outpatient services, and Emergency services that are Covered under this document. Benefits provided by Riders attached to this document are not considered Basic Health Services for the purpose of this definition.]
Benefit Period	The period of time (typically twelve (12) months) during which certain Allowed Amount(s) for Covered Services are accumulated for purposes of determining Coverage provisions, such as, but not limited to, satisfaction of out-of-pocket maximums and benefit limits. Refer to Your Schedule of Benefits to determine the applicable Benefit Period.

Benefit Period Maximum	A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for You in any one year. Once a Benefit Period Maximum is met, no more Covered Services will be provided during the same year.
Coinsurance	Cost-sharing arrangement in which You pay a specified percentage of the cost for a Covered Service.
Coinsurance Maximum	The annual limit of Your coinsurance payments for Covered Services, as specified in the Schedule of Benefits.
Confinement and Confined	An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.
Copayment	Cost-sharing arrangement in which You pay a specified dollar amount as Your share of the cost for a Covered Service.
Coverage or Covered	The benefits provided under this document for Covered Services rendered to You, subject to the terms, conditions, exclusions, and limitations of this document.
Covered Services	The services or supplies provided to You for which the Plan will make payment, as described in the Policy.
Custodial Care	Care is considered custodial when it is primarily for the purpose of helping You 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 You who, in the opinion of the Medical Director, has reached the maximum level of recovery. This term also includes services to an institutionalized individual, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to; respite care and home care which is or which could be provided by family members or private duty caregivers; and vacation or resort facilities that incorporate recreational therapy or rest cures.
Day Program Services	A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.
Deductible	The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Policy.
Dependent	A person defined in the Policy who is eligible to receive Covered Services (usually the spouse or child of a Policyholder).
Designated Transplant Network Facility	A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of

Important Numbers.

Designated Transplant Network Physician

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

Effective Date

The date of Coverage as determined by the Plan and agreed to by You, as set forth in the Policy.

Emergency Medical Condition and Medical Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing Your health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:
 - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 - That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Some examples of an Emergency Medical Condition include, but are not limited to: broken bone; chest pain; seizures or convulsions; severe or unusual bleeding; severe burns; suspected poisoning; trouble breathing; and vaginal bleeding during pregnancy. You may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

Emergency Services

Ambulance services and other Health Care Services rendered or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician, subject to the exclusions and other provisions set out in this document.

Experimental or Investigational

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

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, except as otherwise covered under the Clinical Trial benefit;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 and its administrative

regulations.

Home Health Agency

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

Hospital

An institution, operated pursuant to law, which: (a) is operated for the medical treatment of sick and/or injured persons as inpatients; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, 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.

Maintenance Therapy

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Medical Director

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Prior Authorization programs.

Medically Necessary/Medical Necessity

Those services, supplies, equipment and facility charges that are not expressly excluded under this Policy 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 basic health needs as a minimum requirement;
- 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 without compromising the quality of care;
- 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.

[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.]

Officer

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

Out-of-Pocket Maximum

The annual limit of Your payments for Covered Services, as specified in the Schedule of Benefits.

GLOSSARY

Participating Provider	A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to individuals.
Peer-Reviewed Medical Literature	<p>A phrase defined by two elements:</p> <ul style="list-style-type: none">▪ It refers to the requirement that medical literature on a topic is only considered relevant if it is 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; and▪ Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: <u>strength</u> of the evidence and <u>effectiveness</u>. Strength of evidence is graded from the highest level of evidence to the lowest, as follows: Level 1: Randomized, controlled trial Level 2: Cohort/Case Control Study Level 3: Systematic Literature Review Level 4: Large consecutive case series Level 5: Small consecutive case series Level 6: Textbook chapters (opinion of a respected authority) Level 7: Case report <p>Effectiveness is evaluated using 4 measurements: (1) Is the proposed treatment harmful or beneficial? (2) Do the results favor the study (experimental) group or the control group? (3) Is the outcome considered statistically weak or strong? (4) Is the study design weak or strong?</p> <p>After evaluating the peer-reviewed medical literature according to the methodology described above, a conclusion is drawn that the preponderance of evidence favors the proposed new technology as being proven (and therefore standard of care), or conversely unproven (i.e. investigational/experimental).</p>
Physician/Practitioner	<p>Anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.</p> <p>By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Policy, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.</p>
Plan	Coventry Health & Life Insurance Company.
Policy	This document and Amendments, Application for Coverage and/or Change Form, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Policy.
Premium	The monthly fee required by the Plan for You and each enrolled Dependent in

accordance with the terms of the Policy.

Preventive Services	The services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered is available on the website [www.chckansas.com] or will be mailed to You upon request.
Prior Authorization	The process of obtaining approval for receiving specific health care services prior to those services being rendered. The process includes determination of eligibility, determination of Covered Services, determination of Medical Necessity, and implications about the use of Participating and Non-Participating Providers. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.
Provider	A Physician, Hospital, Home Health Agency, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.
Provider Directory	A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.
Public Entity	A publicly supported medical facility providing care, treatment and supplies to injured or sick individuals through a program or agency owned and operated by a state or county government. This may include but is not limited to entities such as a county hospital or county health clinic.
Residential Treatment Facility	A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.
Residential Treatment Program	A program certified by the department of mental health involving residential care and structured, intensive treatment.
Rider	An Amendment that provides additional Covered Services and is attached to the Policy. Services provided by a Rider may be subject to payment of additional Premiums.
Schedule Of Benefits	A written document, incorporated by reference into this document, that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.
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.
[Service Area	The geographic area served by the Plan and approved by the State Department of Insurance. The Plan's Service Area is subject to change from time to time.]
Skilled Nursing Facility (SNF)	A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily

GLOSSARY

	Custodial Care, including training in Activities of Daily Living.
Special Enrollment Period	The period after the regular Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of this document.
Specialty Care Physician/Specialist	A Physician who is not a Primary Care Physician and provides medical services to individuals concentrated in a specific medical area of expertise.
Substance Abuse	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.
Utilization Review	A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Prior Authorization, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.
We, Us or Our	Coventry Health & Life Insurance Company.
You or Your	An individual covered under this document.

SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

[Customer Services/Claims Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD
www.chckansas.com]

[Prior Authorization Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD]

[Appeals and Grievance Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114]

[MH Net Behavioral Health PO Box 209010
Austin, TX 78720
(866) 607-5970
www.chckansas.com]

**[Arkansas Insurance
Department]** 1200 West Third St
Little Rock, AR 72201
(800) 282-9134
Insurance.Consumers@arkansas.gov