

SERFF Tracking Number: CVKS-127187464 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 48898
Company Tracking Number: CERTIFICATE OF COVERAGE, ET AL
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Certificate of Coverage, et al SERFF Tr Num: CVKS-127187464 State: Arkansas
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 48898
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: CERTIFICATE OF State Status: Approved-Closed
COVERAGE, ET AL

Filing Type: Form

Author: Jennifer Simms Reviewer(s): Rosalind Minor
Date Submitted: 05/26/2011 Disposition Date: 06/28/2011
Disposition Status: Approved-Closed

Implementation Date Requested: 09/01/2011

Implementation Date:

State Filing Description:

General Information

Project Name: Certificate of Coverage, et al

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 06/28/2011

State Status Changed: 06/28/2011

Created By: Jennifer Simms

Corresponding Filing Tracking Number: Certificate of Coverage, et al

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Product filing - Employer Group - any size.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jennifer Simms

Company and Contact

Filing Contact Information

Jennifer Simms, Regulatory Compliance

jesimms@cvtly.com

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Analyst

8320 Ward Parkway 866-795-3995 [Phone] 4539 [Ext]
 Kansas City, MO 64114 816-460-4695 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$700.00
 Retaliatory? No
 Fee Explanation: \$50 x 14 documents
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$700.00	05/26/2011	48069300

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/28/2011	06/28/2011

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	06/22/2011	06/22/2011	Jennifer Simms	06/27/2011	06/27/2011

SERFF Tracking Number: CVKS-127187464 *State:* Arkansas
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Disposition

Disposition Date: 06/28/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CVKS-127187464 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document (revised)	Cover Letter & Statement of Variability	Approved-Closed	Yes
Supporting Document	Cover Letter & Statement of Variability	Replaced	Yes
Supporting Document	PPACA Certification	Approved-Closed	Yes
Supporting Document	Redline Documents (Revisions)	Approved-Closed	Yes
Form (revised)	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Pharmacy Rider	Approved-Closed	Yes
Form	Hearing Aid Rider	Approved-Closed	Yes
Form	TMJ Rider	Approved-Closed	Yes
Form	Mental Health Endorsement	Approved-Closed	Yes
Form	Autism Endorsement	Approved-Closed	Yes
Form	Obesity Rider	Approved-Closed	Yes
Form	HPN/ACO Rider	Approved-Closed	Yes
Form	Group Master Contract	Approved-Closed	Yes
Form	Risk Appraisal Questionnaire (Employer)	Approved-Closed	Yes
Form	Group Application (Employer)	Approved-Closed	Yes
Form	Enrollment Form - Change Request	Approved-Closed	Yes
Form	Enrollment Form & Health Questionnaire	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/22/2011

Submitted Date 06/22/2011

Respond By Date

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage, CHL-AR-COC-011-05.11 (Form)

Comment:

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

Objection 2

- Risk Appraisal Questionnaire (Employer), RAQ-ER-05.11 (Form)

Comment:

If this questionnaire will be used as a stand alone application/enrollment form, it must contain a fraud statement.

Objection 3

- TMJ Rider, CHL-AR-RID-015-05.11 (Form)
- Risk Appraisal Questionnaire (Employer), RAQ-ER-05.11 (Form)
- Group Application (Employer), APP-ER-05.11 (Form)
- Enrollment Form - Change Request, APP-CF-05.11 (Form)
- Enrollment Form & Health Questionnaire , APP-HS-05.11 (Form)

Comment: Will the benefits under the TMJ rider be included in the Certificate for every employer/policyholder that you market the product? As you are aware, TMJ, ACA 23-79-150, is a mandated offering of optional coverage. Under ACA 23-79-150 (c)(1) & (2), the policyholder shall accept or reject the optional coverage in writing on the application.

Further, the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Your applications/enrollment forms did not include the above language.

Objection 4

SERFF Tracking Number: CVKS-127187464 State: Arkansas
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Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al

- Certificate of Coverage, CHL-AR-COC-011-05.11 (Form)

Comment: It is requested that you review ACA 23-99-418 (Act 1155 of 2011) and certify that the pre-certification language and process outlined in the Certificate of Insurance is in compliance with the law.

Objection 5

- Cover Letter & Statement of Variability (Supporting Document)

Comment:

Your cover letter states that the forms are PPACA compliant. It is requested that you fill out PPACA Uniform Compliance Summary as it applies to this submission.

Objection 6

- Cover Letter & Statement of Variability (Supporting Document)

Comment: Your cover letter states that "Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share.

On Page 18 of the Certificate, it is stated with respect to a Non-Participating Physician and a Non Participating Facility, that if there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. Please demonstrate or explain how this is in compliance with our Bulletin 9-85.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Project Name/Number: Certificate of Coverage, et al

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 06/27/2011
 Submitted Date 06/27/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Update to language was made in accordance with ACA 23-86-108(4), per your Objection. Please see the revisions to Form Tab.

Related Objection 1

Applies To:
 - Certificate of Coverage, CHL-AR-COC-011-05.11 (Form)

Comment:

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

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Redline Documents (Revisions)

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate of Coverage	CHL-AR-COC-011-05.11		Certificate	Initial		40.000	CHL-AR-COC-011-05.11.pdf
Previous Version							
Certificate of Coverage	CHL-AR-COC-011-		Certificate	Initial		40.000	CHL-AR-COC-011-

SERFF Tracking Number: CVKS-127187464 State: Arkansas
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Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al
05.11

05.11.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Form RAQ-ER-05.11 is NOT an application but an effort to streamline market efficiency for an employer to determine if Coventry Health & Life is a competitive insurer. The proposal issued based on the receipt and review of this form, is a partially underwritten proposal. If the employer wishes to continue with the process form APP-ER-05.11 and either ApP-CF-05.11 or APP-HS-05.11 must be submitted for a fully underwritten offer of coverage. As such no fraud statement is required; however, Coventry feels it prudent to file this form for your review due to its use in the market.

Related Objection 1

Applies To:

- Risk Appraisal Questionnaire (Employer), RAQ-ER-05.11 (Form)

Comment:

If this questionnaire will be used as a stand alone application/enrollment form, it must contain a fraud statement.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: Benefits under the TMJ Rider are intended to be offered to an employer as Optional Coverage. Optional coverages are depicted within the Underwriting processes where the Employer signs the proposal indicating acceptance/rejection of the Offer of Coverage (and the respective rate associated).

Form APP-ER-05.11 only serves to establish the demographics of the Employer with current insurance contract information so the risk may adequately be assessed. This form is not always issued PRIOR to sell; however, an Underwriting proposal may be issued with RAQ-ER-05.11 and as such the Underwriting proposal is the more appropriate and effective format to disclose the mandated offering of temporomandibular joint disorder or craniomandibular disorder in compliance with ACA 23-79-150 (c)(1) & (2).

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Furthermore, the Coverage purchased by the Employer is expressly attached in form GMC-020-05.11, the Group Master Contract. This Contract is signed between Coventry and the Employer and if purchased, form RID-015-05.11 would be inserted and become a part of such Contract.

Related Objection 1

Applies To:

- TMJ Rider, CHL-AR-RID-015-05.11 (Form)
- Risk Appraisal Questionnaire (Employer), RAQ-ER-05.11 (Form)
- Group Application (Employer), APP-ER-05.11 (Form)
- Enrollment Form - Change Request, APP-CF-05.11 (Form)
- Enrollment Form & Health Questionnaire , APP-HS-05.11 (Form)

Comment:

Will the benefits under the TMJ rider be included in the Certificate for every employer/policyholder that you market the product? As you are aware, TMJ, ACA 23-79-150, is a mandated offering of optional coverage. Under ACA 23-79-150 (c)(1) & (2), the policyholder shall accept or reject the optional coverage in writing on the application. Further, the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Your applications/enrollment forms did not include the above language.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: Pre-certification is delegated to Coventry Health Care of Kansas, Inc. a Private Review Agent (#0429) filed and approved in Arkansas effective 4/25/11. The provisions defined in ACA 23-99-418 (Act 1155) are applicable to this delegated process in which Coventry Health & Life Insurance has received confirmation that prior-authorization and any adverse determination processes are in compliance with this Act.

Related Objection 1

Applies To:

- Certificate of Coverage, CHL-AR-COC-011-05.11 (Form)

SERFF Tracking Number: CVKS-127187464 State: Arkansas
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Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al

Comment:

It is requested that you review ACA 23-99-418 (Act 1155 of 2011) and certify that the pre-certification language and process outlined in the Certificate of Insurance is in compliance with the law.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: Please see Supporting Documentation Tab.

Related Objection 1

Applies To:

- Cover Letter & Statement of Variability (Supporting Document)

Comment:

Your cover letter states that the forms are PPACA compliant. It is requested that you fill out PPACA Uniform Compliance Summary as it applies to this submission.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Cover Letter & Statement of Variability

Comment: Page 18 of the certificate regarding Non-Participating Physician and Non-Participating Facility is in compliance with Bulletin 9-85. These provisions depict the disclosure of how "non-participating" provider fees are calculated. Bulletin 9-85, "2. The difference is benefit levels, i.e., deductibles and co-pay provisions, etc, offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person in contravention of Ark. Stat. Ann. §66-3703," is applicable to the Schedule of Benefits which depicts the differences in benefit level, of which Coventry certifies it will be in compliance.

Satisfied -Name: PPACA Certification

Comment:

SERFF Tracking Number: CVKS-127187464 State: Arkansas
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Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments: Please see explanation under Cover Letter/Supporting Documents Tab.

Related Objection 1

Applies To:

- Cover Letter & Statement of Variability (Supporting Document)

Comment:

Your cover letter states that "Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share.

On Page 18 of the Certificate, it is stated with respect to a Non-Participating Physician and a Non Participating Facility, that if there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. Please demonstrate or explain how this is in compliance with our Bulletin 9-85.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Cover Letter & Statement of Variability

Comment: Page 18 of the certificate regarding Non-Participating Physician and Non-Participating Facility is in compliance with Bulletin 9-85. These provisions depict the disclosure of how "non-participating" provider fees are calculated. Bulletin 9-85, "2. The difference in benefit levels, i.e., deductibles and co-pay provisions, etc, offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person in contravention of Ark. Stat. Ann. §66-3703," is applicable to the Schedule of Benefits which depicts the differences in benefit level, of which Coventry certifies it will be in compliance.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Jennifer Simms

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 Product Name: Certificate of Coverage, et al
 Project Name/Number: Certificate of Coverage, et al

Form Schedule

Lead Form Number: CHL-AR-COC-011-05.11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/28/2011	CHL-AR-COC-011-05.11	Certificate	Certificate of Coverage	Initial		40.000	CHL-AR-COC-011-05.11.pdf
Approved-Closed 06/28/2011	CHL-AR-SOB-012-05.11	Schedule	Schedule of Benefits Pages	Initial		40.000	CHL-AR-SOB-012-05.11.pdf
Approved-Closed 06/28/2011	CHL-AR-RID-013-05.11	Certificate Amendmen t, Insert	Pharmacy Rider	Initial		40.000	CHL-AR-RID-013-05.11.pdf
Approved-Closed 06/28/2011	CHL-AR-RID-014-05.11	Certificate Amendmen t, Insert	Hearing Aid Rider	Initial		40.000	CHL-AR-RID-014-05.11.pdf
Approved-Closed 06/28/2011	CHL-AR-RID-015-05.11	Certificate Amendmen t, Insert	TMJ Rider	Initial		40.000	CHL-AR-RID-015-05.11.pdf
Approved-Closed 06/28/2011	CHL-AR-END-016-05.11	Certificate Amendmen t, Insert	Mental Health Endorsement	Initial		40.000	CHL-AR-END-016-05.11.pdf
Approved-	CHL-AR-	Certificate	Autism Endorsement	Initial		40.000	CHL-AR-

<i>SERFF Tracking Number:</i>	<i>CVKS-127187464</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Coventry Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48898</i>
<i>Company Tracking Number:</i>	<i>CERTIFICATE OF COVERAGE, ET AL</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>Certificate of Coverage, et al</i>		
<i>Project Name/Number:</i>	<i>Certificate of Coverage, et al/</i>		
Closed	END-017-	Amendmen	END-017-
06/28/2011	05.11	t, Insert	05.11.pdf
		Page,	
		Endorseme	
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Approved-	CHL-AR-	Certificate Obesity Rider	Initial
Closed	RID-018-	Amendmen	40.000
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		Page,	018-05.11.pdf
		Endorseme	
		nt or Rider	
Approved-	CHL-AR-	Certificate HPN/ACO Rider	Initial
Closed	RID-019-	Amendmen	40.000
06/28/2011	05.11	t, Insert	CHL-AR-RID-
		Page,	019-05.11.pdf
		Endorseme	
		nt or Rider	
Approved-	CHL-AR-	Policy/Cont Group Master	Initial
Closed	GMC-020-	ract/Fratern Contract	40.000
06/28/2011	05.11	al	CHL-AR-
		Certificate	GMC-20-
			05.11.pdf
Approved-	RAQ-ER-	Application/ Risk Appraisal	Initial
Closed	05.11	Enrollment Questionnaire	
06/28/2011		Form (Employer)	RAQ-ER-
			05.11.pdf
Approved-	APP-ER-	Application/ Group Application	Initial
Closed	05.11	Enrollment (Employer)	
06/28/2011		Form	APP-ER-
			05.11.pdf
Approved-	APP-CF-	Application/ Enrollment Form -	Initial
Closed	05.11	Enrollment Change Request	
06/28/2011		Form	APP-CF-
			05.11.pdf
Approved-	APP-HS-	Application/ Enrollment Form &	Initial
Closed	05.11	Enrollment Health Questionnaire	
06/28/2011		Form	APP-HS-
			05.11.pdf



Health Care Benefits

Arkansas

PREFERRED PROVIDER ORGANIZATION (“PPO”)

CERTIFICATE OF COVERAGE (“COC”)

IMPORTANT NOTICE

THIS COC, THE SCHEDULE OF BENEFITS AND ALL ATTACHED RIDERS/ENDORSEMENTS SHOULD BE READ IN THEIR ENTIRETY.

You have the full freedom of choice in the selection of any duly licensed health care professional. This COC has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers are used. Please consult this Certificate of Coverage, 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]



Welcome to Coventry Health & Life Insurance Company!

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

As a Coventry Health & Life Insurance Company Insured, it is important that You understand the way Your Plan operates. This COC contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials so that You are aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com any time for additional information.

We look forward to serving You.

Sincerely,

[Michael Murphy]

Chief Executive Officer

Table of Contents

Coventry Health & Life Insurance Company
Certificate of Coverage

The Agreement between **Coventry Health & Life Insurance Company** (hereafter called the “Plan”) and You and between the Plan and Your Dependents and is made up of:

- This Certificate of Coverage (“COC”) and Amendments;
- Application Form;
- Applicable Riders;
- Provider Directory; and
- Schedule of Benefits.

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

THIS AGREEMENT SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Agreement and understanding Your relationship to the Plan, You can be an informed participant. You should keep this COC in a safe place for Your future reference. Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement will appear capitalized because they have special meaning and are defined for You in Section 1. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Agreement may be amended. When that occurs, the Plan will provide an Amendment or new COC to You for this Agreement.

You may examine a copy of this COC, the Group Master Contract, the Group Application for Benefit Offerings, individual Subscriber Employee Enrollment/Change Form, Amendments, Schedules and Riders at the office of the Employer Group during regular business hours.

The Plan is responsible for making benefit determinations in accordance with the Group Master Contract, this COC and the Plan’s agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim for payment or Pre-Certification of a recommended service, the Member may request reconsideration of that decision through the Plan’s Member Complaint and Grievance Procedure described in this COC.

Definitions

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

“Activities of Daily Living”

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

“Acute”

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

“Administrative Appeal”

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; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Insured and the Plan.

“Alternate Facility”

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:

- 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.

“Amendment”

Any attached written description of additional or alternative provisions to the COC and/or this COC. Amendments are effective only when Authorized in writing by the Plan and are subject to

Definitions

all conditions, limitations and exclusions of the COC except for those which are specifically amended.

“Ancillary Provider”

A Provider who is not licensed as a Physician or a Hospital.

“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.

“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 Health Insurance Portability and Accountability Act (“HIPAA”) privacy purposes.

“Benefit Maximum”

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for the Insured in any one Benefit Year. Once a Benefit Maximum is met, no more Covered Services will be provided during the same Benefit Year.

“Benefit Year”

The period of time during which the total amount of annual benefits under Your Coverage is calculated. Your COC may be issued on either a Calendar Year or Contract Year. Please call the customer service number on the back of your ID card to obtain information about Your Benefit Year.

“Calendar Year”

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

“Chronic Condition”

A health condition that is continuous or persistent over an extended period of time.

“Coinsurance”

Cost-sharing arrangement in which the Insured pays a specified percentage of the cost for a Covered Service.

“Coinsurance Maximum”

The annual limit of a Insured’s coinsurance payments for Covered Services, as specified in the Schedule of Benefits”

“Complaint”

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

“Confinement” and “Confined”

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

“Contract Year”

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

Definitions

Date and each subsequent anniversary.

“Copayment”

Cost-sharing arrangement in which the Insured pays a specified dollar amount as their share of the cost for a Covered Service.

“Cosmetic Services and Surgery”

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

“Coverage” or “Covered”

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

“Covered Services”

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

“Custodial Care”

Care is considered custodial when it is primarily for the purpose of helping the Insured 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 the Insured who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Insured, 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.

“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 COC.

“Dental Services”

Services primarily for the prevention, diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

“Dependent”

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

“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 an agreement with a Designated Transplant Network Facility to render Medically

Definitions

Necessary and medically appropriate services for Covered transplants.

“Durable Medical Equipment”

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

“Elective Abortion”

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Insured upon whom the abortion is performed.

“Eligible Employee”

An individual employed by the Employer Group who meets all the eligibility requirements specified in the Agreement including, but not limited to, this COC, the Group Application for Benefit Offerings, and the Group Master Contract.

“Eligible Expenses”

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

“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 the Insured’s health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part; or
- Inadequately controlled pain.

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; or
- Vaginal bleeding during pregnancy.

The Insured may seek medical attention from a Hospital, Physician’s office or some other Emergency facility.

“Emergency Services”

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this COC.

“Employer Group”

The employer or other legally constituted group with whom the Group Master Contract is made.

“Employee Enrollment/Change Form”

Definitions

Your application for enrollment in the Plan.

“ERISA”

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

“Experimental or Investigational”

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

- Any drug not approved for use by the Federal Food and Drug Administration (“FDA”); any drug that is classified as an Investigational New Drug (“IND”) by the FDA; or any drug that is proposed for off-label prescribing. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
 - Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

“FDA”

Federal Food and Drug Administration.

“Group Master Contract (“GMC”)

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

“Group Effective Date”

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

“Group Enrollment Period”

The period of time occurring at least once annually during which time any Eligible Employee may enroll with the Plan.

“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.

“Home Health Care Services”

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

“Hospice”

An organization or entity whose primary purpose is to furnish medical services and supplies only to patients who are considered to be terminally ill. The Plan has the right to determine whether a facility is a Hospice facility.

Definitions

“Hospital”

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; 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.

“Illness”

Physical ailment, or disease. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

“IND”

Investigational New Drug.

“Infertility”

Any medical condition causing the inability or diminished ability to reproduce.

“Infertility Services”

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

“Injury”

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

“Inquiry”

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

“Insured”

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions and for whom, or on whose behalf, Premiums have been received and accepted by the Plan.

“Institutional Review Board (“IRB”)”

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

“Limiting Age”

The maximum age a non-Spouse Dependent can be to maintain eligibility under the terms of the Plan, and as defined in the Group Master Contract.

“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.

“Material Misrepresentation”

Medical or other information not disclosed on the application, or as it relates to Covered Services, which, if it had been disclosed, would have affected the acceptance of coverage, benefits offered or provided and/or Premium charged.

“Maternity Services”

Definitions

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

“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 Pre-Certification programs.

“Medically Necessary/Medical Necessity”

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

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

“Medical Necessity Appeal”

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.

“Medicare”

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

“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.

“Mental Illness” or “Mental Health”

Those conditions classified as “mental disorders” in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

“NIH”

National Institutes of Health.

“Non-Participating Provider”

Definitions

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

“Officer”

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

“Orthotic Appliances”

Orthotic Appliances correct or support a defect of a body form or function.

“Out-of-Pocket Maximum”

The annual limit of an Insured’s payments for Covered Services, as specified in the Schedule of Benefits.

“Participating Provider”

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Insured.

“Peer-Reviewed Medical Literature”

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

“Physician/Practitioner”

Means 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.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan’s obligation under the COC, 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.

“Plan”

Coventry Health & Life Insurance Company.

“Post-Service Appeal”

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

“Pre-Certification”

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

“Preventive Services”

Shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered available on our website at [www.chckansas.com] or will be mailed to you upon request.

“Pre-Existing Condition”

Any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such

Definitions

services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

“Pre-Existing Condition Exclusion Period”

The period of time for which Covered Services are excluded for a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period begins on Your Effective Date of Coverage.

“Pre-Service Appeal”

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

“Premium”

The monthly fee required from Insured in accordance with the terms of the COC.

“Prosthetic Devices”

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

“Provider”

A Physician, Hospital, 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.

“Reconstructive Surgery”

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

“Retiree”

A former Eligible Employee of the Employer Group who meets the Employer Group’s definition of retired employees to whom the Employer Group offers Coverage under this COC and Group Master Contract.

“Rider”

An Amendment that modifies Covered services and is attached to the COC. Services provided by a Rider may be subject to payment of additional Premiums.

“Self-Injectables”

Injectable Prescription Drugs as specified in the Plan’s formulary list, that are commonly and customarily administered by the Insured according to clinical guidelines used by the Plan.

“Semi-private Accommodations”

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private

Definitions

Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.

“Special Enrollment Period”

The period after the regular Group Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of COC.

“Spouse”

A Subscriber’s Spouse or eligible former Spouse as defined by applicable state law or court decree.

“Subscriber”

The Eligible Employee or Retiree who meets all the requirements as set forth in this COC and the Group Master Contract and who has elected the Plan’s Coverage for himself/herself and any eligible Dependents through submission of an Employee Enrollment/Change Form and for whom, or on whose behalf, Premiums have been received by the Plan.

“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.

“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.

“Therapeutic Injections and IV Infusions”

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

“Total Disability”

Complete inability of the Insured to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Insured to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability of the Insured must require regular care and attendance by a Physician who is someone other than an immediate family member.

“Urgent Care”

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

“Urgent Care Appeal”

An Appeal for which a requested service requires Pre-Certification, 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 the Insured or the Insured’s unborn child; or (b) the Insured’s 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.

“Utilization Review”

Definitions

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, Pre-Certification, 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”

The Insured Covered under this COC.

Using Your Benefits

Identification (“ID”) Card

Every Insured will receive 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 an Insured 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 the ID card and in the Schedule of Important Numbers. 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 this COC.

Health Services Rendered By Participating Providers

An Insured has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the COC. Coverage for services described in this COC and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses of this COC. Participating Providers are contractually obligated to file all claims for You.

It is the Insured’s 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. The Insured is responsible for verifying the status of the Provider by contacting the Customer Service Department or by checking the Plan’s website at [www.chckansas.com].

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

Notice of Claim

The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits. A Non-Participating Provider may or may not complete and file the claim form for You. Written notice of claim must be submitted to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the COC, or as soon thereafter as is reasonable.

Claim Forms

You may obtain a Non-Participating claim form from the Plan’s Customer Service Department within fifteen (15) days from the date the Plan receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss,

within the time fixed for filing a claim.

Proofs of Loss

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 Insured's failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of legal capacity of the claimant, when You submit proof of loss to the Plan more than twelve (12) months from the date services were provided by the Non-Participating Provider.

Processing of the Filed Claim

We make claim payment decisions based on the information provided on the submitted claim form. We make every effort to process claims upon receipt of the Proof of Loss. All Covered Services payable under the COC shall be paid not more than thirty (30) days after receipt of the completed claim form, and subject to the Proof of Loss provision of this COC. If We deny all or part of Your claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the COC. We will also notify You if additional information is necessary to process the claim.

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 must 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 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 prior year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession 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 prior year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the prior year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the Plan's Average Wholesale Price ("AWP"). Payment for anesthesia services will be 200% of the prior year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DME POS") will be at the prior year DME POS ceiling limit. Payment for Laboratory services will be at the prior year 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.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Insured’s responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided to You. To request a copy contact the Plan’s Customer Service Department’s telephone number listed on Your ID card or by visiting the Plan’s website at [www.chckansas.com].

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this COC are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Insured.

Failure to obtain Pre-Certification will result in a reduction of benefits. To find out the amount of the penalty, please see the Schedule of Benefits. Any penalty applied does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Insured’s responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines medical necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a Material Misrepresentation or omission about the Insured’s health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Insured’s Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

An Insured may seek a second medical opinion or consultation from any Provider. An Insured should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the COC.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to 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 contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan's Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. 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, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

How to Contact The Plan

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

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

Participating 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 COC, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the Insured or a person, other than the Plan or intermediary, acting on behalf of the Insured for services provided pursuant to this COC. This COC shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the EOC, 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 Coverage to You.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the COC. 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 COC. The Plan shall have the right, subject to Your rights under this COC, to interpret the benefits of this COC and attached Riders, and other terms, conditions, limitations and exclusions set out in the COC in making factual determinations related to the COC, its benefits, and the Insured; 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 COC must be in accordance with Eligibility & Termination of this COC. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan

Using Your Benefits

does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Eligibility & Termination

Eligibility

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

- Be an Eligible Employee of the Employer Group, and eligible to participate equally in any alternate health benefits plan offered by the Employer Group by virtue of his/her employment status;
- Meet any eligibility criteria specified by the Employer Group and approved by the Plan, including, without limitation, the criteria set forth in the Group Master Contract; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

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

Be the lawful Spouse of the Subscriber or be the child of the Subscriber or the Subscriber's Spouse including:

- Children up to their twenty-sixth (26) birthday who are either the birth children of the Subscriber or the Subscriber's Spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
- Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Subscriber 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;

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Retirees

A Retiree or Retiree's Spouse who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B Coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement.

Change of Employer Group's Eligibility Rules

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

Eligibility & Termination

Persons Not Eligible to Enroll

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

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

Late Enrollees are not eligible to enroll except during the next Group Enrollment Period, or during a Special Enrollment Period.

Enrollment

All individuals meeting the eligibility requirements of this section may enroll with the Plan for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

Any new employee may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment.

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

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

Special Enrollment

Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee waived Coverage under the Plan at the time Coverage was most recently made available because the Eligible Employee or Dependent had group health plan or health insurance coverage (as defined by the Federal HIPAA Law) at the time Coverage under the Plan was offered and the Eligible Employee's or Dependent's other coverage:

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

Eligibility & Termination

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

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

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

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

Non-Participating Eligible Employee. An Eligible Employee who is eligible but has not yet enrolled may enroll, within thirty-one (31) days from the date of marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

Non-Participating Spouse. Your Spouse may enroll within thirty-one (31) days of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).

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.

New Dependents of non-enrolled Eligible Employee. A child who becomes a Dependent of a non-enrolled Eligible Employee as a result of marriage, birth, adoption or placement for adoption may enroll within thirty-one (31) days of that event, but only if the non-enrolled Eligible Employee is eligible for enrollment and enrolls at the same time.

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Effective Date of Coverage. Coverage shall become effective the day of the qualifying event or the last day of coverage, whichever is later.

Notification of Change in Status. A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Employee Enrollment/Change Form to the Plan. Events

Eligibility & Termination

qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or Coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

Effective Date

During Group Enrollment Period: An Eligible Employee or Retiree, and their Eligible Dependent(s), who enroll during a Group Enrollment Period shall be Covered under this Agreement as of the date stated in the Group Master Contract.

Newly Hired Employees: A newly hired Eligible Employee, and their Eligible Dependent(s), shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage, according to the terms of the Group Master Contract, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Newly Eligible Employees: An Eligible Employee, and their eligible Dependent(s), who become eligible for Coverage under this Agreement during the contract year, shall be Covered as of the first (1st) day of the month following the date that he or she first becomes eligible so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Special Enrollees: Special enrollees shall be Covered under this Agreement as provided day of the qualifying event or the last day of coverage, whichever is later.

Qualified Medical Child Support Order ("QMCSO"): Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order ("QMCSO") shall be Covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Employer Group of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Employer Group, the parties may change the required Premium contribution of Subscribers.

Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in this Health Plan if either of the following two conditions are satisfied.

Termination of Medicaid or CHIP Coverage. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

Eligibility & Termination

Eligibility for Employment Assistance Under Medicaid or SCHIP. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

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

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

Termination of Coverage

Your Coverage shall terminate, upon the Plan's provision of a thirty-one (31) day notice, if any one of the following events occurs:

You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, upon termination of the Subscriber from Employment; the Member entering active military service; divorce or legal separation from the Subscriber; or when a Dependent child reaches the Limiting Age.

You are retired or pensioned, unless the Employer has included Retirees or those pensioned as eligible as referenced in the Group Master Contract.

You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the thirty-one (31) days notice period (and any grace period, if applicable), 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 thirty-one (31) days notice period (and any grace period, if applicable).

Termination of Coverage without Notice. Your Coverage shall immediately terminate if any one of the following events occurs:

- You participate in fraudulent or criminal behavior, including but not limited to:
 - √ Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
 - √ Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.
- Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application. The validity of the policy shall not be contested, except for non-payment of premiums, after the Plan has been in force for two years from the date of issue, and no initial statement made by a Member regarding insurability shall be

Eligibility & Termination

used as a reason for disenrollment after the Plan has been in force for two years from the date of issue.

- Termination or non-renewal of the Group Master Contract, by the Employer Group.
- The Plan receives written notice from the Employer Group instructing the Plan to terminate Your Coverage.

Effect of Termination.

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

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

If the Member receives 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.

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

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the COC, 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 COC shall be without prejudice to any continuous loss which commenced while the COC was in force, but the extension of benefits beyond the period the COC was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the COC.

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.

Covered Services

Covered Services

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this COC, and (4) incurred while the Insured is eligible for Coverage under the Plan. It is the Insured's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Schedule of Covered Services**, provides the services and supplies Covered under this COC. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this COC. 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 in the schedule below are subject to all applicable Exclusions and Limitations of this COC.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Allergy	Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	Exclusions: See Exclusion Section relating to allergy services.
Ambulance (air and ground)	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.	Exclusions: See Exclusion Section regarding ambulance services.
Blood and Blood Products Processing	Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this COC.	Exclusions: See Exclusion Section regarding blood and blood products.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for (1) augmentation and reduction of the affected breast, (2) augmentation or reduction on the opposite breast to restore symmetry, (3) prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.	Exclusions: See Exclusion Section regarding Reduction or Augmentation Mammoplasty.
Cardiac Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	improvement of Your condition.	
Chemotherapy	Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.	Limitations: Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Insured pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.	
Contraceptive Devices	Coverage is provided for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.	
Dental Services	<p>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:</p> <p>(1) 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</p> <p>(2) The patient is:</p> <p>(A) 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;</p> <p>(B) A person with a diagnosed serious mental or physical condition; or</p> <p>(C) A person with a significant behavioral problem as determined by the Insured's physician.</p> <p>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.</p>	<p>Limited benefit.</p> <p>Exclusions: See Exclusions Section regarding dental services.</p>
Dermatological Services	Coverage is provided for the necessary removal of a skin lesion that interferes with normal body	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	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 Supplies	Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes.	Limitations: Disposable insulin syringes, 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 this COC.
Durable Medical Equipment (“DME”)	<p>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 member.</p> <p>The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME.</p>	<p>Upgrades to equipment are the responsibility of the Insured.</p> <p>Exclusions: See Exclusions Section regarding DME Coverage.</p>
Emergency Services	Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and Pre-Certification is not required.	You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.
Eye Glasses and Corrective Lenses	Not a Covered Service, except for the first pair of eyeglasses or corrective lenses following cataract surgery	Exclusions: See Exclusions Section regarding eyeglasses and contact lenses.
Genetic Counseling and Studies	Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	abnormalities and the testing will alter the outcome of treatment.	
Gynecological Examinations	Coverage is provided for routine well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.	
Hearing Screenings	Coverage is provided for a hearing screening to determine hearing loss.	
Home Health Care Services	<p>Coverage is provided when <u>all</u> of the following requirements are met:</p> <ul style="list-style-type: none"> (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the agency rendering services is licensed by the State of location. 	Exclusions: See Exclusions Section regarding Home Services.
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Insured 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, and guidance and assistance during the Illness for the purpose of preparing the Insured and the Insured's family for a terminal Illness.	
Infertility Treatment	<p>Coverage is provided for You or Your Spouse the patient's oocytes are fertilized with the sperm of the patient's spouse, and</p> <ul style="list-style-type: none"> ▪ a history of unexplained infertility of at least two (2) years' duration; or ▪ the infertility is associated with one or more of the following medical conditions: <ul style="list-style-type: none"> ○ Endometriosis; ○ Exposure in utero to Diethylstilbestrol, commonly known as DES; ○ Blockage of or removal of one or both fallopian tubes (lateral or bilateral 	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>salpingectomy) not a result of voluntary sterilization; or</p> <ul style="list-style-type: none"> ○ Abnormal male factors contributing to the infertility, and ▪ when performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization; ▪ unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy. <p>Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.</p>	
Inpatient Hospital Care	<p>Coverage includes semi-private accommodations and associated professional and ancillary services.</p> <p>Certain services rendered during the Insured's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.</p>	<p><u>Exclusions:</u> See Exclusions Section regarding Private inpatient room.</p>
Laboratory and Pathology Services	<p>Coverage is provided as listed in the Schedule of Benefits.</p>	
Maternity Services	<p>Maternity-related Covered Services are treated as any other Illness. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. Inpatient Hospital services may be subject to Insured responsibility as defined in the Schedule of Benefits.</p>	<p><u>Exclusions:</u> See Exclusions Section regarding maternity services.</p>

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Newborn Care	<p>The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria (“PKU”) and such other common metabolic or genetic diseases.</p> <p>Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.</p>	
Nutritional Counseling	Coverage is provided when provided by a registered dietician.	
Oral Surgery and Diseases of the Mouth	<p>Coverage includes only oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.</p> <p>Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.</p>	Exclusions: See Exclusions Section regarding oral surgery and dental services.
Orthotic Devices	Coverage is provided for the initial 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 <u>only</u> if the Insured has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.	Exclusions: See the Exclusions Section regarding Orthotic Appliances.
Osteoporosis	Coverage is provided for services related to diagnosis, including central bone density tests; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.	
Outpatient Diagnostic Services	Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any other outpatient diagnostic service. Also covered	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.	
Outpatient Surgery	Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Provider at a Hospital or Alternate Facility.	
Outpatient Therapy Services	Coverage is provided for short-term outpatient therapy services that are expected to result in significant functional improvement of the Insured's condition, limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.	Exclusions: See Exclusions Section.
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.	
Physician Services	Coverage is provided for Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.	
Preventive Services	<p>The preventive health services referenced below shall be covered, in a manner consistent with Section 2713 of Federal H.R. 3590.</p> <p>A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;</p> <p>B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention ("ACIP - CDC");</p> <p>C. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and</p> <p>D. Additional preventive care and screenings for women (including breast cancer screening and</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>mammography screenings) not described in paragraph (A).</p> <p>A list of the preventive services covered under this paragraph 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 Service number on Your identification card.</p>	
Prosthetic Devices	<p>Coverage is provided for the initial 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, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.</p> <p>Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Insured; (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.</p> <p>Prosthetics will be replaced for documented growth in a child requiring replacement.</p> <p>Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.</p>	<p>Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal prosthetic devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit.</p> <p><u>Exclusions:</u> See Exclusions Section regarding Prosthetic Devices.</p>
Pulmonary Rehabilitation Services	<p>Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.</p>	
Radiation Therapy	<p>Coverage is provided for standard radiation therapy.</p>	
Radiology	<p>Coverage is provided as determined by the Plan.</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.	<p>Limitations: Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for dependent children [through age eighteen (18)].</p> <p>Exclusions: See Exclusions Section regarding Cosmetic Services and Surgery.</p>
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Insured's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.	<p>Exclusions: See Exclusions Section regarding rehabilitation services and supplies.</p>
Sleep Studies	Covered Services.	<p>Exclusions: See Exclusion Section regarding sleep studies.</p>
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility. Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	<p>Limitations: Coverage in a Skilled Nursing Facility may be subject to a Benefit Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during the Insured's Confinement are subject to separate benefit restrictions and/or Insured responsibilities as described elsewhere in this COC or in the Schedule of Benefits.</p>
Spinal Manipulation Services	<p>The following services are Covered when they are delivered by a duly licensed Provider acting within the scope of his or her license:</p> <ul style="list-style-type: none"> • Initial Examinations <p>Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Insured's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems may be done if appropriate clinical indications</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>are present and documented. Vital signs should be included in examinations when appropriate.</p> <ul style="list-style-type: none"> • Subsequent Office Visits <p>This may include an adjustment, a brief examination and other Medically Necessary services.</p> <ul style="list-style-type: none"> • Re-examination <p>This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.</p>	
Sterilization (voluntary)	Covered Service.	Exclusions: See Exclusions Section regarding reversal of sterilization.
Therapeutic Injections and IV Infusions.	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.	<p>Limitations: Certain Self-Injectable medications may be Covered by a pharmacy Rider and therefore excluded from the medical benefit.</p> <p>Exclusions: See Exclusions Section regarding Prescription medications.</p>
Transplants	<p>Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is an Insured.</p> <p>Donor screening tests are Covered and when performed at a Coventry Transplant Network participating facility.</p> <p>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-Insured when the recipient is an Insured will be Covered for the duration of the COC.</p> <p>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.</p> <p>The cost of any care, including complications,</p>	Exclusions: See Exclusions Section regarding transplant services.

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>arising from an organ donation by the Insured when the recipient is not an Insured is excluded.</p> <p>If the Insured resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.</p>	
Urgent Care Services	<p>Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician <u>will not</u> result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.</p>	
Vision Services	<p>Coverage is provided for eye examination to include, if Medically Necessary, 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.</p>	<p><u>Exclusions:</u> See exclusions section regarding Vision Services.</p>

Exclusions and Limitations

General Exclusions

Unless otherwise stated in this COC, the following items are excluded from Coverage:

- 1) 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 COC;
- 2) Any service or supply that is not Medically Necessary;
- 3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;
- 4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the COC;
- 5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
- 6) Court-ordered services or services that are a condition of probation or parole;
- 7) Those services otherwise Covered under the COC, but rendered after the date Coverage under the COC terminates, including services for medical conditions arising prior to the date individual Coverage under the COC terminates; and
- 8) 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 the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

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

- 1) **Acupuncture** - Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;
- 2) **Allergy Services** - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
- 3) **Alternative Therapies** - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;
- 4) **Ambulance Service** - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;
- 5) **Augmentative Communication Devices** – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;
- 6) **Autopsy** - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;
- 7) **Behavior modification;**
- 8) **Biofeedback;**

Exclusions and Limitations

- 9) **Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;**
- 10) **Blood Storage** - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;
- 11) **Braces and supports needed for athletic participation or employment;**
- 12) **Charges resulting from Your failure to appropriately cancel a scheduled appointment;**
- 13) **Cochlear Implants** and related services;
- 14) **Cosmetic Services and Surgery** - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;
- 15) **Counseling Services** and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
- 16) **Custodial Care**, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured 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 regardless of who orders the services;
- 17) **Dental Services** - Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this COC. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.

Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service
- 18) **Dental Surgery and Implants** - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;
- 19) Medical services and expenses incurred for learning disabilities, **developmental delays**, mental retardation, and autistic disorders.
- 20) **Durable Medical Equipment ("DME")** - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or

Exclusions and Limitations

negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;

- 21) **Educational Services** Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
- 22) **Equipment** or services for use in altering air quality or temperature;
- 23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;
- 24) **Elective or Voluntary Enhancement** - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;
- 25) **Eligible Expenses** - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;
- 26) **Enteral Feeding Food Supplement** - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;
- 27) **Examinations** - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;
- 28) **Exercise equipment**, hot tubs and pools;
- 29) **Eye Glasses and Contact Lenses** - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;
- 30) **Food or food supplements** , regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;
- 31) **Foot Care** – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;
- 32) **Foreign Travel** - care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;
- 33) **Growth Hormone** – Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

Exclusions and Limitations

- 34) **Hair analysis, wigs and hair transplants** - Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;
- 35) **Home services to help meet personal, family, or domestic needs;**
- 36) **Health and Athletic Club Membership** - Any costs of enrollment in a health, athletic or similar club;
- 37) **Hearing Services and Supplies** - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;
- 38) **Household Equipment and Fixtures** - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;
- 39) **Hypnotherapy and Hypnosis;**
- 40) **Immunizations** unless specifically covered under the COC, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;
- 41) **Infertility/Reproductive Services** - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility, except as described in Covered Services; and reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the COC;
- 42) **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;
- 43) **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;
- 44) **Male Gynecomastia** – Those services and associated expenses for treatment of male gynecomastia.
- 45) **Massage Therapy** – Those services and associated expenses related to massage therapy;
- 46) **Medical complications** arising directly or indirectly from a non-Covered Service;

Exclusions and Limitations

- 47) **Mental Health Services** - the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;
- 48) **Military Health Services** - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- 49) **Miscellaneous Service Charges** - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;
- 50) **Non-Prescription Drugs and Medications** - Over-the-counter (“OTC”) drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider;
- 51) **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 under for PKU, Amino or Organic Acid Inherited Disease for food or formula;
- 52) **Newborn** home delivery and also the cost of child birth classes;
- 53) **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, jejunal 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;
- 54) **Occupational Injury** - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this COC;
- 55) **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;
- 56) **Orthodontia** and related services;
- 57) **Orthotic Appliances, Repairs or Replacement** - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

Exclusions and Limitations

- 56) **Over-the-counter supplies** such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also 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, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider;
- 59) **Personal comfort and convenience** items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;
- 60) **Prescription Drugs and Medications** - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider.
- 61) **Private Duty Nursing** - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;
- 62) **Prosthetic Devices Repairs or Replacement** - The 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 owned by the Insured;
- 62) **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;
- 64) **Reduction or Augmentation Mammoplasty** - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;
- 65) **Reversal of Sterilization Services** - Those services and associated expenses related to reversal of voluntary sterilization;
- 66) **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;
- 67) **Sexual Dysfunction** - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;
- 68) **Sleep Studies – Sleep studies provided within the home;**
- 69) **Smoking Cessation** - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;
- 70) **Speech therapy** or voice training when prescribed for stuttering or hoarseness;
- 71) **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 and orthotics;
- 72) **Substance Abuse** diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;
- 73) **Surrogate motherhood** services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

Exclusions and Limitations

- 75) **Transplant Organ Removal** - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the COC unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;
- 76) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the COC;
- 77) **Transplant Services** and associated expenses involving temporary or permanent mechanical or animal organs;
- 78) **Travel Expenses** - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;
- 79) **Treatment for disorders** relating to learning, motor skills and communication;
- 80) **Vision Aids, Associated Services** - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;
- 81) **Vocational therapy**;
- 82) Health services resulting from **war or an act of war** when the Insured is outside of the continental United States; and
- 83) **Work hardening programs**.

Coordination of Benefits

This section describes how Benefits under this COC will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

A **Plan**, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

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

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

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

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

Coordination of Benefits

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

“Joint Custody” If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined below.

Order of Benefit Determination Rules

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

- The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- 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.
- 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 Insured other than as a Dependent, for example as an employee, Insured, Subscriber or retiree is Primary and the Plan that covers the Insured as a Dependent is Secondary. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Insured as a Dependent; and Primary to the Plan covering the Insured 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 Insured as an employee, Insured, 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:
 - 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
 - If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

Coordination of Benefits

- 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 Insured as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Insured 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.
- √ Continuation coverage. If a Insured 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 Insured as an employee, Insured, Subscriber or retiree (or as that Insured'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 Insured as an employee, Insured, 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. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

Effect On The Benefits of the Plan

- The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

- a) If an employee is eligible for Medicare and works for an Employer Group with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, then Medicare will be the primary payer. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis.
- b) If an employee works for an Employer Group with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding the Calendar Year, the Plan will be primary. However, an employee may decline Coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare -Covered services.

Coordination of Benefits

You will continue to be Covered by the Plan as primary unless You (a) notify the Plan, in writing, that You do not want benefits under the Plan or (b) otherwise cease to be eligible for benefits under the Plan, or (c) if we determine through some other means that we are not the primary carrier.

Disability

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

End Stage Renal Disease (“ESRD”)

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

Coordination of Benefits for Retirees

- a) If You are retired and You or one of Your Dependents is Covered by Medicare Part A and/or Part B (or would have been Covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:
 - (i) Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
 - (ii) Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been Covered by Medicare; or
 - (iii) Amounts paid under all other plans in which You participate.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

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

Facility of Payment

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

Right of Recovery

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

- The persons it has paid; or
- For whom it has paid; or
- Insurance companies; or
- Other organizations.

Right of Reimbursement

In consideration of the coverage provided by this COC, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as “Third Parties”. You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - √ Providing any relevant information requested by Us,
 - √ Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
 - √ Responding to requests for information about any accident or injuries,
 - √ Making court appearances, and
 - √ Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;

Coordination of Benefits

- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or a non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Complaints & Appeals

The Insured may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Insured or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this COC.

Complaints

A complaint is an 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.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company
[P.O. Box 7109]
[London, KY 40742]
Telephone: [(800) 969-3343]

Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Insured and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. The Appeals must be made within 180 days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health & Life Insurance Company
Attn: Appeals Department
[8320 Ward Parkway]
[Kansas City, MO 64114]

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

One level of internal Appeal is provided if You, or your Authorized Representative, disagree with an Adverse Benefit Determination. The Insured or Authorized Representative may file an Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that field of medicine.

- Appeals are concluded as follows:

- √ Urgent Care Appeals –Urgent Care Appeals will be completed within 72 hours after receipt of the Appeal request. We will notify the Insured and/or Authorized Representatives verbally and provide a follow-up written notice within 3 calendar days after the verbal notification.

Complaints & Appeals

- √ Pre-service Appeals – Requests for Pre-service Appeals will be acknowledged by letter upon receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 30 calendar days of receipt of the Appeal request;
- √ Post-service Appeals – Requests for Post-service Appeals will be acknowledged by letter upon receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 60 calendar days from the date of the request for a Appeal.

Our written notification to the Insured or Authorized Representative will provide the reason for the decision. Our notice will give the Insured or Authorized Representative instructions on any additional Appeal Rights available. The written notice will also include information on applicable review processes available under state law.

External Appeals

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. Only appeals that are related to an Adverse Determination that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend five hundred dollars (\$500) or more are afforded an external independent review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service. The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. The independent review organization shall make a determination and verbally notify You, Your authorized representative, Your attending Physician and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

Contact Information

You may contact your respective the 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.

Continuation of Coverage

Consolidated Omnibus Budget Reconciliation Act (“COBRA”)

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

Insureds who selected continuation Coverage under a prior plan which was replaced by Coverage under this COC shall be Covered until termination as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier.

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

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

Continuation Coverage Under Arkansas State Law

Covered Person whose coverage under the Group Policy are entitled to continue their Hospital, surgical or major medical coverage, including coverage for their eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- You have been Covered for at least a three (3) month period before termination;
- You were not terminated for cause as permitted by the Group Master Contract;
- The discontinued group Coverage was not replaced with similar group Coverage within thirty-one (31) days;
- You are not and do not become eligible for Medicare Coverage; and
- You are not eligible for any other Hospital, Physician and/or major medical Coverage for individuals in a group.

Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period

The Covered Person must do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Employer Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the Group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify You, in writing, of its duties under this subdivision not later

Continuation of Coverage

than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

- The date four (4) months after the date Your Coverage under this COC would have terminated because of termination of employment;
- If You fail to make timely payment of a required Premium contribution, the end of the period for which contributions were made;
- The date this COC is terminated or, in the case of a Subscriber, the date the Employer Group terminates participation under the Agreement. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Agreement, then You shall have the right to become covered under that other policy for the balance of the period that:
 - You would have remained covered under this COC in accordance with the conditions of this section;
 - The minimum level of Benefits to be provided by the other Agreement shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and
 - The prior Group Agreement shall continue to provide Benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

- Reasons for termination:
- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Agreement ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for Fraud or Misrepresentation;
- The Group Agreement terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Agreement within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this COC. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this policy.

Continuation of Coverage

The converted policy shall cover You and Your dependents who were covered by this COC on the date of termination of insurance. At the option of the Plan, a separate converted policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar benefits by another policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

General Provisions

Applicability

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

Governing Law

This COC is delivered and governed by the laws of the State of Arkansas for Arkansas residents.

Legal Actions

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

You must exhaust the Plan's Complaint and Appeal Procedures prior to pursuing legal action, (in a court or other government tribunal) as this may be the most expeditious and cost-effective method of resolving Your concerns.

Time Limit On Certain Defenses

After two years from the date of issue of this Agreement no misstatements, except fraudulent misstatement, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this Agreement 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 Agreement.

Nontransferable

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

Relationship Among Parties Affected by this Agreement

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

Neither the Employer Group nor You are agents or representatives of the Plan, and shall not be liable for any acts or omissions of the Plan for the performance of services under this Agreement.

Contractual Relationships

The Plan agrees with the Employer Group to provide Coverage for services to You, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Employer Group's Group Master Contract. This COC is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Group Master Contract in place between the Plan and the Employer Group, and the Employer Group's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Employer Group is given thirty-one (31) days advance written notice.

General Provisions

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

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

COC's will be provided to the Employer Group by the Plan for distribution to all Insureds.

The Plan is Not Employer

The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Employer Group's benefit plan. The Plan shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Employer Group's benefit plan.

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 the Insured. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

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

Entire Agreement

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this Agreement. Amendments to the COC are effective upon thirty-one (31) days written notice to the Insured. No change will be made to the Agreement unless made by an Amendment or a Rider that is issued by the Plan. No agent or representative has authority to change the Agreement or to waive any of its provisions.

This Agreement, including all matters incorporated, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Agreement, including the application agreement, and all endorsements, exhibits, addenda, or amendments, if any, supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Valid Amendment

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

Waiver

General Provisions

The failure of the Plan or You to enforce any provision of this COC 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 COC shall not be deemed or construed to be a waiver of such default.

Records

The Insured 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 Agreement in the event the Plan is unable to obtain this information directly from the Provider or previous insurer.

By accepting Coverage under the COC, the Insured, who has signed the application, authorizes and directs any person or institution that has provided services to the Insured, to furnish the Plan or any of the Plan's designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Insured. 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 the COC or for appropriate medical review or quality assessment.

Examination of the Insured

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 the Insured at the Plan's expense.

ERISA

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

Clerical Error

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

Notice

Written notice given by the Plan to an Employer Group, or an Authorized Representative of the Employer Group, is deemed notice to all affected Subscribers and their enrolled Dependents in the administration of Coverage under the COC, including termination of Coverage. The Employer Group is responsible for giving notice to Insureds.

Workers' Compensation

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

Conformity with Statutes

Any provision of the Agreement 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

General Provisions

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

Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by or on behalf of a Insured, 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 Agreement.

Discretionary Authority

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

Value Added Services

From time to time the Plan may offer to provide Insureds access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Plan is not liable to the Insureds 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.

Important Numbers & Addresses

<p>Customer Service / Claims</p> <p>[Coventry Health & Life Insurance Company Customer Service PO Box 7109 London, KY 40742</p> <p>(800) 969-3343</p> <p>(866) 285-1864 TDD</p> <p>http://www.chckansas.com/]</p>	<p>Pre-Certification</p> <p>[Coventry Health & Life Insurance Company 8320 Ward Parkway Kansas City, MO 64114</p> <p>(877) 837-8914]</p>
<p>Appeals and Grievance</p> <p>[Coventry Health & Life Insurance Company Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114]</p>	<p>Arkansas Department of Insurance</p> <p>[1200 West Third St Little Rock, AR 72201</p> <p>(800) 282-9134 Insurance.Consumers@arkansas.gov]</p>
<p>[MH Net Behavioral Health]</p> <p>[PO Box 209010 Austin, TX 78720 (866) 607-5970</p> <p>www.chckansas.com]</p>	

Benefit	Insured Responsibility	
	Participating Providers	Non-Participating Providers ²
[Deductible⁴¹] [(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-Pocket⁴¹] 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.	\$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]

<ul style="list-style-type: none"> Immunizations-Pediatric (Up to age 72 months) 	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
<ul style="list-style-type: none"> Mammogram [Diagnostic] [and] Routine Screening 	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
<ul style="list-style-type: none"> Colonoscopy [Diagnostic] [and] Routine Screening 	\$0 Copayment	[\$0-\$500] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
Outpatient Laboratory Services		
<ul style="list-style-type: none"> 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]
<ul style="list-style-type: none"> 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]
<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Radiology 	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
<ul style="list-style-type: none"> Diagnostic Services 	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³]	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³]
<ul style="list-style-type: none"> Dialysis 	[\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</i>	[\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] <i>[Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]]</i>

<ul style="list-style-type: none"> Surgery and Scopes 	<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>		
<ul style="list-style-type: none"> Inpatient hospital care, including semi-private room & board, intensive/coronary care, [maternity care,] x-ray, laboratory, professional services and other facility & ancillary charges. Inpatient Rehabilitation [Limited to [10 – 200] days per [Calendar Year] [Contract Year]][Benefit Year]] 	<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>		
<ul style="list-style-type: none"> Ambulance/Emergency Transportation (Ground or Air) 	<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>

<ul style="list-style-type: none"> At an Urgent Care Center 	<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>
<ul style="list-style-type: none"> At a Hospital Emergency Room [(Copayment waived if admitted)] 	<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>
<ul style="list-style-type: none"> [Emergency Room] [Related Professional Fees] 	<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>
Short Term Therapies		
<ul style="list-style-type: none"> Physical Therapy, Occupational Therapy & Speech Therapy [Limited to [10 – 200] visits [per Therapy] per [Calendar Year] [Contract Year] [Benefit Year]] 	<p>[\$0-\$500] [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%-70%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>
<ul style="list-style-type: none"> Cardiac and Pulmonary Rehabilitation [Limited to [10 – 200] visits per [Calendar Year] [Contract Year] [Benefit Year]] 	<p>[\$0-\$500] [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%-70%] [Coinsurance] [AD³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]</p>

<ul style="list-style-type: none"> Partial Day Programs (4 hours or greater) [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]]
<ul style="list-style-type: none"> Chiropractic Services/Spinal Manipulation [Limited to [4 – 200] Visits per [Calendar Year] [Contract Year] [Benefit Year]] 	[Same as Specialist Physician Office Visit] [\$0-\$500] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[Same as Specialist Physician Office Visit] [\$0-\$1,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]
Other Services		
[Eye Exam] [including refraction] [Refraction Services Limited to [1 – 6] exams every [12 – 48] Months]	[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]
Infertility Treatment [Limited to [\$1,000 - \$15,000] per [Calendar Year] [Contract Year] [Benefit Year]]	[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]] [See Appropriate Benefit] [Same as Maternity OB/GYN Benefit]	[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]] [See Appropriate Benefit] [Same as Maternity OB/GYN Benefit]
Injectable Medications (Not listed elsewhere)	[\$0-\$1,000] [Copayment] [and] [plus] [0%-50%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]	[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year]][Benefit Year]]

<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</p> <ul style="list-style-type: none"> ▪ [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>[\$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</p> <ul style="list-style-type: none"> ▪ 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>[\$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>

Prosthetics & Braces	[\$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]]
Organ / Tissue Transplant <i>[Services provided at approved Coventry Transplant Centers] [only]</i>	See Appropriate Benefit	[\$0-\$2,000] [Copayment] [and] [plus] [0%-70%] [Coinsurance] [AD ³] [Limited to [1 – 5] Copayments per [Calendar Year] [Contract Year][Benefit Year]] <i>[See Appropriate Benefit]</i>

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.]



PRESCRIPTION DRUG RIDER

This Prescription Drug Rider (“Rider”) is made a part of Coventry Health and Life Insurance Company’s Individual Policy (“Policy”). The benefits provided by this Rider become effective on the date Coverage under the Policy is effective.

PRESCRIPTION DRUG BENEFITS

Subject to the terms, conditions and scope of coverage, including all Exclusions, Limitations and defined terms of the Policy unless otherwise provided in this Rider, [and] Insured Responsibility [and Ancillary Charges], outpatient Prescription Drugs will be Covered as listed below, when:

- Medically Necessary
- the Insured is eligible to receive Covered Services;
- written by a Prescribing Provider;
- [included on the Formulary]; and
- filled at a pharmacy.

[Generically equivalent pharmaceuticals will be dispensed whenever there is an FDA approved Formulary Generic drug.] [If you choose to receive a brand name Prescription Drug when a Formulary Generic Drug is available, You will be responsible for the] [Ancillary Charge] [and the] [Non-Formulary] [Formulary] [Insured Responsibility]. [The Ancillary Charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written."] [Your total Insured Responsibility shall not exceed the] [average wholesale price (“AWP”)] [total] [allowable] [cost] [of the Prescription Drug.]

Benefit ^{[2] [3] [4]}	Insured Responsibility		
	Participating Pharmacy	Non-Participating Pharmacy	[Mail Order]
[Deductible][and] [Coinsurance] ^{[2] [3]} ([per Calendar Year] [per Contract Year] [per Benefit Year])	[Individual:] [\$0 - \$15,000] [Family:] [\$0 - \$45,000] [The amount listed under the Schedule of Benefits]	[Individual:] [\$0 - \$30,000] [Family:] [\$0 - \$60,000] [The amount listed under the Schedule of Benefits]	[The amount listed under the Schedule of Benefits] [See applicable Participating or Non-Participating Pharmacy Insured Responsibility]
[Formulary] [Tier 1][A] [Prescription] [and] [Specialty Drugs]	[\$0-\$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [whichever is greater] [AD ¹] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000] [Coinsurance] [Out-of-Pocket] ^{[2] [3]} [Maximum (per [Benefit Year])]	[\$0-\$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD ¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000] [Coinsurance] [Out-of-Pocket] ^{[2] [3]} [Maximum (per [Benefit Year])]	[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]

<p>[Formulary] [Tier 1][B] [Prescription Drugs] [and] [Specialty Drugs]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]</p>
<p>[Formulary] [Tier 2] [Prescription Drugs] [and] [Specialty Drugs]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]</p>
<p>[Non-Formulary] [Tier 3] [Prescription Drugs] [and] [Specialty Drugs]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]</p>
<p>[Formulary] [Diabetic Prescription Drugs, Supplies and Insulin]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[\$0-\$200] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]</p>
<p>[Formulary] [and] [Non-Formulary] [Tier 4] [Specialty Drugs]</p>	<p>[\$0-\$500] [Copayment] [and] [plus] [or] [0%-50%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[\$0-\$500] [Copayment] [and] [plus] [or] [0%-70%] [Coinsurance] [AD¹] [whichever is greater] [up to a [\$100-1,000] maximum per individual prescription] [Not Covered] [\$0 - \$30,000][Subject to the] [Coinsurance] [Out-of-Pocket]^[2]^[3] [Maximum (per [Benefit Year]) [amount listed under the Schedule of Benefits]</p>	<p>[1] [1.5] [2] [2.5] [3] [times the thirty-one (31) day designated Insured Responsibility.] [Not Available] [Not Covered]</p>

<p>[Tier] [1][A][B][2][3][4] [Coinsurance] [Out-of-Pocket] ^[2] ^[3] [Maximum (per Benefit Year)] <i>[includes [Copayments], [Coinsurance], and [Deductible]]</i></p>	<p>[Individual:] [\$0 - \$30,000] [Family:] [\$0 - \$60,000] [The amount listed under the Schedule of Benefits]</p>	<p>[Individual:] [\$0 - \$30,000] [Family:] [\$0 - \$60,000] [The amount listed under the Schedule of Benefits]</p>	<p>[The amount listed under the Schedule of Benefits]] [See applicable Participating or Non-Participating Pharmacy Insured Responsibility]</p>
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[Benefit Maximums]	
<p>[Benefit Year Benefit Maximum] ^[3]</p> <ul style="list-style-type: none"> • [Prescription Drugs] • [Specialty Drugs] 	<p>[Individual:] [\$1,000 - Unlimited] [Family:] [\$1,000 - Unlimited] [The amount listed under the Schedule of Benefits]</p> <p>[Individual:] [\$1,000 - Unlimited] [Family:] [\$1,000 - Unlimited] [The amount listed under the Schedule of Benefits]</p>
<p>[Lifetime Benefit Maximum] ^[3]</p>	<p>[\$1,000,000 – Unlimited] [The amount listed under the Schedule of Benefits]</p>

1. [AD means After Deductible. The [coinsurance] [and] [copayment] requirement applies after You have satisfied the [annual] Deductible requirement.]
2. [Copayments] [,] [Deductible] [and] [Ancillary Charges] [do not] apply to the [Out-of-Pocket] [Coinsurance] [Maximum listed on the Schedule of Benefits.]
3. [Copayments] [,] [Deductible] [and] [,] Ancillary Charges [,] [Benefit Maximum] [,] [and] [Lifetime Maximum] [do not] [apply to the] [Lifetime] [and] [Benefit Year] [Maximum listed on the Schedule of Benefits].
4. To find Your Prescription Drug, its applicable Tier and any Pre-Certification requirements, visit Our searchable Formulary on Our website www.chckansas.com, in the Participating Provider’s office, or by contacting the Customer Service Department.

The following also apply:

- Insured Responsibility is due each time a prescription is filled or refilled, up to a thirty-one (31) day supply for Retail and Specialty Pharmacy, and up to a ninety-three (93) day supply for Mail Order Pharmacy.
- [Select over-the-counter medications as determined by the Plan in an equivalent prescription dosage strength will be covered under this Rider for the [Tier 1][A][B] [Formulary] [Non-Formulary] [appropriate] Insured Responsibility. Coverage of the selected over-the-counter medications requires a physician prescription.]
- Only one drug and “Rx Unit” will be dispensed per prescription. The Rx Unit quantity is determined by FDA labeling, the dosage required or the Plan Formulary guidelines. Please note: Insured Responsibility is required for each Rx Unit, container, or prepackaged item.
- If a Prescription Drug covered is prescribed in a single dosage amount for which the particular prescription drug is not manufactured in such single dosage amount and requires dispensing the particular prescription drug in a combination of different manufactured dosage amounts, the Insured Responsibility will be the same as if the Prescription Drug was manufactured in such single dose.
- Insureds presently taking a prescription drug shall be notified either electronically, or in writing (upon request of the enrollee), at least thirty (30) days prior to any deletions to the Formulary. Notifications will not be provided for Generic substitutions.

- [Value Formulary drugs are offered at no Insured Responsibility on a **temporary basis** to Insureds that are on or have recently received certain drugs(s) and/or receive a new prescription for certain drug(s), as designated by the Plan to promote effective and efficient use of the Plan drug benefits. These drugs are listed in an addendum to the Formulary, which may be found on the our website at [\[www.chckansas.com\]](http://www.chckansas.com). The formulary addendum shall also identify the Plan Criteria applicable to the Value Formulary Drugs. **This formulary addendum may change from time to time without prior notice.** Insureds that appear to meet the Plan criteria for Value Formulary Drugs (as such information is available in Plan's claims records) will be notified if they qualify for a Value Formulary drug, when such drugs are temporarily added. Please note, just because a Insured fills a prescription for a Value Formulary drug does not qualify him/her to receive such drug at no Insured Responsibility. Rather, only Insureds that meet Plan criteria will receive the selected drug at no Insured Responsibility. If a Insured does not satisfy the Value Formulary drug Plan criteria, the drug shall be subject to its applicable Insured Responsibility]

DEFINITIONS

Any capitalized terms used in this Rider and not otherwise defined herein shall have the meaning set forth in the COC. The following definitions apply to this Rider:

[Ancillary Charge]. A charge in addition to the Insured Responsibility You are required to pay for a Prescription Drug which, through Your request or that of the Prescribing Provider, has been dispensed by the brand name, even though a [Formulary] Generic is available. The Ancillary Charge, if any, shall be the difference between the Plan's contracted price for the Non-Formulary or Formulary brand name drug and the contracted price of the generic drug.. The Ancillary charge will be in addition to the appropriate Insured Responsibility. You are responsible at the time of service for payment of the Ancillary Charge directly to the Pharmacy. The Ancillary Charge is not a Covered charge and does not apply to an Deductible, Coinsurance, or Out-of-Pocket Maximum.]

[Coinsurance]. The amount in which the Insured pays a specified percentage of the cost for a Covered Service.] [You are responsible at the time of service for payment of the Coinsurance directly to the Pharmacy.]

[Copayment]. The amount You will be charged by the Pharmacy to dispense or refill any Prescription.] [You are responsible at the time of service for payment of the Copayment directly to the Pharmacy.]

[Deductible]. The amount, which must be satisfied each Benefit Year, before benefits subject to the Deductible are payable under this Rider. [You are responsible at the time of service for payment of the Prescription directly to the Pharmacy, until your Deductible is met.]

Formulary. A list of specific generic and brand name Prescription [and Specialty] Drugs Authorized by the Plan, and subject to periodic review and modification at least annually by the Plan's Pharmacy and Therapeutics Committee. The Formulary is available for review in the searchable Formulary on Our website, [\[www.chckansas.com\]](http://www.chckansas.com), in the Participating Provider's office, or by contacting the Customer Service Department. Please note: Inclusion of a drug within the Formulary does not guarantee that Your health care provider will prescribe that drug for a particular medical condition or illness.

Formulary Prescription Drug. A Prescription [and Specialty] Drug that appears on the Plan's Formulary.

Generic Prescription Drug. A Prescription Drug as being prescribed by its generic and chemical name heading according to the principal ingredient(s) and approved by the Food and Drug Administration.

Mail Order Pharmacy. A Pharmacy that dispenses Maintenance Medications pursuant to a 93 day/cycle supply. Prescription Drugs determined by the Plan to be Maintenance Medications on the Formulary and prescribed by a Prescribing Provider can be filled by mail order.

Maintenance Medication(s). A medication that is listed and identified on the Formulary as a maintenance prescription.

Insured Responsibility. The dollar amount detailed under Prescription Drug Benefits which must be paid by You to a Pharmacy providing a Prescription Drug covered by this Rider.

Non-Formulary Prescription Drug. A Prescription Drug that is not on the Plan's list of Formulary Prescription Drugs.

Non-Participating Pharmacy. Any pharmacy that is not a Participating Pharmacy as defined herein. [A Prescription Order or Refill may be obtained through a Non-Participating Pharmacy, however, You may be required to pay for the cost of the Prescription Drug(s) and file a claim for reimbursement.]

Participating Pharmacy. A pharmacy licensed in the State in which it is located that has entered into a written contract with the Plan to provide services to the Plan's Insureds, or on whose behalf a written contract has been made with the Plan which is in effect at the time services are provided.

[Pre-Certification. Some drugs require Pre-Certification in order for them to be Covered Services. Drugs requiring Pre-Certification are identified within the Formulary with "PA" next to the name of the drug.]

Prescribing Provider. Any person holding the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, or Doctor of Dental Surgery or any other provider who is duly licensed in the United States to prescribe medications in the ordinary course of his or her professional practice.

Prescription Drug(s). Any medication or drug which:

- is provided for outpatient administration;
- has been approved by the Food and Drug Administration; and
- under federal or state law, is dispensed pursuant to a prescription order (legend drug).

This definition of Prescription Drug may include some over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies), psychotherapeutic drugs used for treatment of mental illness, other than when administered in a hospital or provider's office, and a compound substance when it meets the Plan's criteria and the product is not available commercially.

Prescription Order or Refill. The authorization for a legend Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Retail Pharmacy. Prescription Drugs prescribed by a Prescribing Provider and obtained through a Pharmacy.

Specialty Drug. Those drugs listed on the Specialty Drug Formulary and identified with an “SP”. Specialty Drugs are typically used to treat rare or complex disease. These drugs frequently require special handling, close clinical monitoring and management and Pre-Certification prior to being dispensed.

Specialty Pharmacy. A pharmacy that is designated as a Specialty Pharmacy by the Plan for Specialty Drug Prescription Orders or Refills.

[Step Therapy. A process where the Plan or its designee determines that a Prescription Order or Refill based upon information provided by the Prescribing Provider, the Prescription Order or Refill satisfies the Pre-Certification requirements for Coverage. Certification must be obtained prior to dispensing.]

LIMITATIONS

1. Authorized refills will not be provided after the lesser of:
 - i. twelve (12) months from the original date on the prescription order; or
 - ii. the period of time limited by state or federal law.
2. [Contraceptive diaphragms prescribed by a Prescribing Provider are limited to two (2) per year.]
3. [Coverage of injectable drugs is limited to [Specialty Drugs as determined by the Plan] [and] insulin, [glucagon], [bee sting kits], [Imitrex] [and] [injectable contraceptives] that are commonly and customarily administered by the Insured.]
4. Selected products, as defined by the plan, with narrow therapeutic index, potential for misuse and/or abuse, high cost, or a narrow or limited range of Food and Drug Administration approved indications may require Pre-Certification.
5. The Pharmacy shall not dispense a Prescription Drug order which, in the Pharmacist’s professional judgment, should not be filled.
6. To promote appropriate utilization, or following manufacturer’s recommendations, certain plan approved medications may have a quantity limit on the amount of medication dispensed and pre-certification must be obtained prior to dispensing.
7. We reserve the right to include only one dosage or form of a drug on our Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Formulary will be Covered at the applicable Insured Responsibility. The drug, product or products, in different forms or dosages or from the same or different manufacturers, not listed on the Formulary will be [excluded from coverage] [subject to Tier 3].

8. Coverage of Prescription Drugs, therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Plan approved drugs, devices, supplies, or spacers for metered dose inhalers.
9. [Coverage through the Mail Order Pharmacy is not available on drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances or anticoagulants.]
10. [When You use a Non-Participating Prescribing Provider, it is Your responsibility to contact the Plan before a Prescription Order or Refill is filled to obtain any required Pre-Certification. If the Plan is not contacted for Pre-Certification, You will be required to pay one hundred percent (100%) of the cost for a Prescription Drug.]

EXCLUSIONS

The following are **Excluded** from Coverage under this Rider:

1. Prescription Drugs related to the treatment of a Non-Covered Service (i.e. dental services).
2. Prescription Drugs that are not Medically Necessary. The Plan reserves the right to require medical Pre-Certification for selected drugs before providing Coverage.
3. Prescription Drugs that are Experimental or Investigational, including those labeled “Caution-limited by Federal Law to Investigational Use,” FDA approved drugs used for investigational indications or at investigational doses and drugs found by the FDA to be ineffective or given as a part of a study.
4. Products not approved by the FDA, Prescription Drugs with no FDA approved indications, and DESI Drugs. This exclusion shall not apply to a drug, medicine or medication that is recognized for the treatment of cancer in one of the standard reference compendia or in substantially accepted peer-review medical literature.
5. Any Prescription Drug which is to be administered, in whole or in part, while You are in a hospital, medical office or other health care facility.
6. Compounded prescriptions [are excluded unless all of the following apply:
 - a. there is no suitable commercially-available alternative available;
 - b. the main active ingredient is a Covered Prescription Drug;
 - c. the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and
 - d. the claim is submitted electronically by the Pharmacy.]
7. Vitamins and minerals (both over-the-counter and legend), except as specified on the Formulary.
8. [Injectable medications] [and] [Specialty Drugs], [except those designated by the Plan.]

9. Drugs that do not require a prescription by federal or state law, that is, over-the-counter drugs or over-the-counter products, unless specifically designated for Coverage by the Plan or the Formulary list and obtained from the Pharmacy with a Prescription Order or Refill. Also excluded are Prescription medications that are not for treatment of illness, injury, or have an over-the-counter equivalent, unless otherwise specified on the Formulary.
10. Devices or supplies of any type, even though requiring a Prescription Order, such as but not limited to, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes or other devices, regardless of their intended use, unless otherwise specified as a Covered benefit in this Rider.
11. [Contraceptive implant systems], [and] [prescription] [or] [nonprescription contraceptive devices (e.g., condoms[,] [and] spermicidal agents[, and Norplant]).]
12. [Extemporaneous dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including but not limited to oral capsules, suppositories, creams and troches.]
13. [Prescription Drugs used for the treatment of impotence.]
14. [Anti-smoking medication or smoking cessation devices.]
15. [Prescription Drugs used to treat chemical dependency and/or substance abuse.]
16. [Drugs used primarily for hair restoration.]
17. [Pharmacological therapy for weight reduction, dietary supplements, appetite suppressants, and other drugs used to treat obesity, morbid obesity or assist in weight reduction.]
18. [Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating infertility, fertilization, and/or artificial insemination.]
19. Medications used for cosmetic purposes or to enhance work or athletic performance (i.e. Nuvigil or Provigil for shift work, anabolic steroids and minoxidil lotion, retin A (tretinoin) for aging skin). Also excluded are drugs, oral or injectable, used to slow or reverse normal aging processes (i.e. growth hormone, testosterone, etc.).
20. Prescription Drugs dispensed in unit doses, when bulk packaging is available, or repackaged Prescription Drugs.
21. Replacement for lost, destroyed or stolen prescriptions.
22. Duplicate drug therapy (i.e. two antihistamine drugs).
23. Oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Formulary.
24. Prescriptions that You are entitled to receive without charge under any Workers' Compensation law, occupational statute, or any law, or regulation of similar purpose.

25. [Tier 2] [and] [,] [Tier 3] [and] [,] [Tier 4] [and] [Non-Formulary drugs, devices and supplies]; [unless otherwise defined in this Rider.]

CONDITIONS

1. The Plan and its designees shall have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of this Rider or for appropriate medical/pharmaceutical review or quality assessment.
2. The Plan shall not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not Covered under this Rider.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the COC 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 COC, other than as stated above.
3. Discounts and Rebates. Insured understands and agrees that Health Plan may receive a retrospective discount or rebate from a Network Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Insured shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective premium calculations.

[Signature of Company Officer]
[Title of Company Officer]



HEARING AID RIDER

This Hearing Aid 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 Certificate of Coverage (“COC”). The benefits provided by this Rider become effective on the date Coverage under the COC is effective.

DEFINITIONS

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

“Hearing Aid”

An instrument or device, including repair and replacement parts, that is designed and offered for the purpose of aiding persons with or compensating for impaired hearing, is worn in or on the body; and is generally not useful to a person in the absence of a hearing impairment.

BENEFITS

Coverage is provided for medical treatment of Hearing Aids when medically appropriate and when dispensed by an approved provider. Coverage is limited to one hearing aid per ear in a three year period and is not subject to any COC deductible or copayment.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the COC 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 COC, other than as stated above.

[Signature of Company Officer]



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 Certificate of Coverage (“COC”). The benefits provided by this Rider become effective on the date Coverage under the COC is effective.

DEFINITIONS

All definitions of the COC 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 COC 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 COC, other than as stated above.

[Signature of Company Officer]



MENTAL HEALTH SUBSTANCE USE ENDORSEMENT

This Mental Health Substance Use 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 Certificate of Coverage (“COC”). The benefits provided by this Endorsement become effective on the date Coverage under the COC is effective.

MENTAL HEALTH SUBSTANCE USE BENEFITS

Subject to the terms, conditions and scope of coverage, including all Exclusions, Limitations and defined terms of the COC unless otherwise provided in this Endorsement, recognized Mental Illness Substance Abuse benefits will be provided under this endorsement as follows:

- 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 as listed in the Schedule of Benefits.

The Plan contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all biologically based Mental Illnesses, psychiatric conditions, and Substance Abuse.

If You have any questions about Your Mental Health and Substance Abuse Coverage, the appropriate way to access Coverage, or to Pre-Certify care for Mental Health and Substance Abuse, you must contact the contracted vendor. The vendor’s name and telephone number are listed on the back of Your ID card, in the Directory of Health Care Providers, and Important Numbers and Addresses.

DEFINITIONS

Terms that are capitalized herein have the following definitions:

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.

Nonresidential Treatment Program: A program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

Recognized Mental Illness(es): mental illness, alcoholism, drug abuse or substance use disorders specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric..

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.

LIMITATIONS AND EXCLUSIONS

The following types of treatment are excluded in addition to the Exclusions and Limitations in the Policy:

- Services rendered or billed by a school or halfway house.

IMPORTANT NUMBERS & ADDRESSES

[MHNet Behavioral Health
PO Box 209010
Austin, TX 78720
(866) 607-5970

<http://www.chckansas.com/>]

[Signature of Company Officer]



AUTISM SPECTRUM DISORDERS ENDORSEMENT

This Autism Spectrum Disorders Endorsement is attached to and made part of the Coventry Health and Life Insurance Company ("Coventry") Certificate of Coverage ("COC").

BENEFIT

Subject to the terms, conditions and scope of coverage, including all Exclusions, Limitations and defined terms of the COC unless otherwise provided in this Endorsement, Autism Coverage benefits will be provided under this endorsement as follows:

Autism Spectrum Disorders - Coverage is provided up to age eighteen (18) for the Medically Necessary Treatment for Autism Spectrum Disorders when ordered by a treating Physician or licensed psychologist. Benefits are subject to the appropriate benefits as defined on the Schedule of Benefits.

LIMITATIONS

The coverage required under this Endorsement is not subject to any visit limits. However, treatment plans and prior authorization may be required. [Applied behavior analysis shall have an annual limitation of \$50,000.]

Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Please contact customer service at the number on the back of your ID card.

DEFINITIONS

Terms that are capitalized herein have the following definitions:

"Applied Behavioral Analysis"

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

"Autism Spectrum Disorders"

A neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of autism spectrum disorders"

Medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;

"Habilitative or rehabilitative care"

Professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual;

"Pharmacy care"

Medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

"Psychiatric care"

Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

"Psychological care"

Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

"Therapeutic care"

Services provided by licensed speech therapists, occupational therapists, or physical therapists;

"Treatment for Autism Spectrum Disorders"

Care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including, equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

- (a) Psychiatric care;
- (b) Psychological care;
- (c) Habilitative or rehabilitative care, including applied behavior analysis therapy;
- (d) Therapeutic care;
- (e) Pharmacy care.



MORBID OBESITY RIDER

This Morbid Obesity 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 Certificate of Coverage (“COC”). The benefits provided by this Rider become effective on the date Coverage under the COC is effective.

DEFINITIONS

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

“Body Mass Index”

Body weight in kilograms divided by height in meters squared;

“Morbid Obesity”

A weight that is at least two (2) times the ideal weight for frame, age, height, and gender of an individual. Morbid Obesity may be measured as a Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or greater than forty (40) kilograms per meter squared.

BENEFITS

Coverage is provided for Medically Necessary treatment of Morbid Obesity, including gastric bypass surgery, adjustable gastric banding surgery, sleeve gastrectomy surgery, and duodenal switch biliopancreatic diversion. Benefits will be offered under the same extent as other medically necessary surgical procedures as defined by the Schedule of Benefits.

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the COC 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 COC, other than as stated above.

[Signature of Company Officer]



[PPO SELECT] [CONFIDENT CARE] RIDER

This [PPO Select] [Confident Care] (“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 Certificate of Coverage (“COC”). The additional benefits provided by this Rider become effective on the date that Your Group purchased this supplemental Rider (“Effective Date”) and expires when Your Group Coverage under this Rider terminates. Accordingly, all definitions, provisions, terms, limitations, exclusions, and conditions of the COC apply to this Rider except to the extent such terms and conditions are explicitly superseded or modified by this Rider.

INTRODUCTION

This product is designed as a new model for delivering quality care health care services to You while keeping Your costs down. This product, provides You with a two-tiered benefit system and network of providers. The Tier One network will include [all of the [PPO Select] [Confident Care] network of providers]. The [PPO Select] [Confident Care] [network] will have in place: a sufficient number of primary care physicians who will assist You in coordinating Your care so that there is less duplication of services; leadership and management structures, including clinical and administrative systems; and processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care, such as through the use of telemedicine, remote patient monitoring and other enabling technologies.

This [PPO Select] [Confident Care] product necessitates a variety of changes to Your existing COC, all as set forth below:

DEFINITIONS

“Primary Care Physician (PCP)”

A Participating [PPO Select] [Confident Care] Provider who practices in the fields of Internal Medicine, Family Practice, General Practice, or Pediatrics who is designated as an [PPO Select] [Confident Care] PCP by the Plan and who is responsible for providing care to You or referring You to other Providers in order to receive care. Note: Female Insureds may also select a Woman’s Principal Health Care Provider (WHPCP) in addition to their PCP. This physician specializes in women’s health care needs and practices in the fields of Family Practice or Obstetrics and Gynecology.

USING YOUR BENEFITS

Your PCP

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. You and Your PCP will work together to maintain Your health, and Your PCP should be able to provide or coordinate most of Your health care needs. This may include providing preventive Health Services, obtaining Authorization of certain services, consulting with Specialists and other Providers, and Emergency Services.

Selecting Your PCP

You may choose Your PCP from the Provider Directory, a list of Participating family and general practitioners, internists, and pediatricians. When selecting a PCP, You may wish to contact individual Provider offices for additional information, such as specifics of a Physician’s training and experience or office hours and policies. One PCP may be selected for the entire family, or each Dependent may select a different PCP. If You do not choose a PCP within 31 days of enrollment or within 31 days of being notified that Your PCP is no longer Participating with the Plan, one will be assigned to You by the Plan.

Changing Your PCP

Should You wish to change Your PCP, You should contact the Plan’s Customer Service Department or visit the Plan’s website, [chckansas.com].

Referrals and Authorization

In the event You require a Specialist’s services or Hospitalization, Your PCP can assist you in the coordination of Your care. In order to receive coverage at Your Tier One or in-network level of benefits, all care must be obtained from an [PPO Select] [Confident Care] Participating Provider unless specifically Authorized by the Plan in accordance with the Plan’s policies and procedures. Coverage for certain Health Services set forth in the Schedule of Benefits obtained from [PPO Select] [Confident Care] Participating Providers requires prior Authorization through the Plan. Your PCP or the [PPO Select] [Confident Care] Participating Provider who admits You to an inpatient or outpatient facility is responsible for obtaining Authorization from the Plan. You are responsible for verifying that the requested Health Services are Covered under their Plan, and the required prior Authorization has been granted before receiving the Health Services. For all other Covered Services, You may make an appointment directly with the designated Provider to obtain the care.

You are not limited to [PPO Select] [Confident Care] Participating Providers in order to receive Coverage under the plan. If you wish to obtain Covered Services from a Physician or other medical Provider who is not in the [PPO Select] [Confident Care] network of Participating Providers, You may seek those services directly from those Providers, but those services will be covered according to your Tier Two or out-of-network level of benefits. If Your PCP refuses to provide a referral to an [PPO Select] [Confident Care] Participating Provider of Your choice, please call the Customer Services Department for assistance. Additionally, PCPs do not have the authority to independently bind the Plan to Coverage for medical services that are not Covered Services as described in Your COC or mandated by state law. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not Your PCP. To verify Coverage of services or Provider participation status, please contact Customer Services at the telephone number listed on Your identification card.

COVERED SERVICES

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS]
[Nutritional & Wellness Coaching]	[Includes visits with a wellness coach to offer advice and guidance on a variety of wellness issues, including: fitness, nutrition, weight management, stress reduction,	[This is a limited benefit.] [Please see Your Schedule of Benefits for details.]

	health risk management and barriers to reaching fitness goals.]	
[E-Visits]	[Includes online medical consultations via e-mail over the internet between Your Physician and You to obtain advice and prescriptions for common conditions such as a cough or cold, diarrhea, urinary infection, sinus problems or pink eye.]	
[Telemedicine]	Telemedicine involves the delivery of health care to You when You are not in the same physical location as Your Provider. With telemedicine, health care is delivered through the use of real time videos or by sending clinical information and/or picture images to Your Provider for consultation, evaluation and/or treatment.]	

[Additional Coverage for Prescription Drugs]

In addition to the coverage outlined in Your existing prescription drug rider, You now also have the following additional prescription drug benefits and Coverage:

[Tier One A and One B Prescription Drug Coverage]

Tier One – Tier One drugs are typically those drugs classified as Generic by the Plan.

Tier One A – Contains a select list of Tier One drugs determined by the Plan be available for a reduced Copayment per prescription for a one-month supply. These drugs are noted by the Plan in the Tier One A drug listing.

[Copayment:
[0-50%] or [\$0 - \$50] Per generic Covered Drug]

Tier One B – Includes the remaining list of drugs from Tier One that are not on Tier One A.

[Copayment:
[0-50%] or [\$0 - \$50] Per generic Covered Drug]

You are entitled to Coverage for Covered Tier One A and/or Tier One B Drugs as listed in the Drug Formulary from a Participating Pharmacy upon payment of the applicable Copayment and/or Deductible as listed above.]

[PRESCRIPTION DRUG COVERAGE]

[Preventive prescription drugs are those that are designed to keep You from developing a health condition. They can help You maintain quality of life and avoid more expensive treatment, which in turn may help You reduce Your health care costs. Examples of preventive prescription drugs include drugs such as cholesterol and blood pressure lowering agents, which reduce risks for heart attack or stroke, or medications for osteoporosis or diabetes.

You are entitled to Coverage for preventive prescription drugs as identified in the Plan's Preventive Drug Formulary from a Participating Pharmacy only upon payment of the applicable Copayment as listed in Your prescription drug rider. In order to encourage You to obtain preventive prescription drugs, the cost of preventive prescription drugs will not be applied to Your medical plan deductible.]

GENERAL PROVISIONS

1. Your Coverage under this Rider will end when Coverage under the COC 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 COC, other than as stated above.

[Signature of Company Officer]

GROUP MASTER CONTRACT

Issued by

**Coventry Health Care of Kansas, Inc.
8320 Ward Parkway
Kansas City, MO 64114
(800) 969-3343
www.chckansas.com**

Issued to

[GROUP NAME]

PPO products are underwritten by Coventry Health and Life Insurance Company
and administered by [Coventry Health Care of Kansas, Inc.]

GROUP MASTER CONTRACT

This Group Master Contract (“Contract”), effective _____ (“Effective Date”), is made between Coventry Health Care of Kansas, Inc. and/or on behalf of Coventry Health and Life Insurance Company (“Plan”) and _____ (“Group”), and sets forth the terms by which the Plan shall arrange for the provision of health care services in accordance with the provisions of the applicable Certificate of Coverage (“COC”), and any Supplemental Benefit Explanations (“Riders”) and amendments thereto, to the Group’s eligible Employees and their eligible Dependents who enroll within the Plan. It is understood and agreed that no benefits will be provided until such time as this Contract has been executed by the Plan.

1. Definitions

Capitalized terms used in this Contract shall be defined as set forth in the COC.

2. Group Obligations

2.1 Provision of Information

The Group shall furnish to the Plan the following information pertaining to the Group’s Eligible Employees and Eligible Dependent(s) on a regular basis, as determined by the Plan:

- a Quarterly Wage and Tax Statement or a completed Certified List of Employees form on an annual basis, or as requested by the Plan;
- a listing of those individuals who qualify for and elect to become Covered;
- notification when Covered individuals change their type of Coverage;
- notification when Covered individuals are no longer eligible for Coverage or when their Coverage ends; and
- notification of all address changes for each Employee and/or their Eligible Dependent(s).

2.2 Eligibility Determination

The Group is responsible for determining whether an Employee and their Dependent(s) are eligible for Coverage hereunder. Such eligibility shall be determined in accordance with the eligibility criteria outlined within the COC, and as further defined in Addendum 1 of this Contract. Failure to determine Employee and Dependent eligibility pursuant to this Contract shall constitute breach thereof.

2.3 Enrollment/Disenrollment

The Group shall notify the Plan of the enrollment or disenrollment of an Eligible Employee and/or their Eligible Dependent(s) by submitting a completed Employee Enrollment / Waiver of Coverage / Health Statement Form (“Enrollment Form”) to the Plan, or electronically in a format and manner acceptable to the Plan. The Group shall require Employees to complete the Enrollment Form within thirty-one (31) days from the date the Employee is eligible to enroll. The Group shall forward the Enrollment Form to the Plan within five (5) business days of receiving the completed form or information from the Employee.

The Plan will not accept a retroactive enrollment change if the enrollment or disenrollment date is earlier than sixty (60) days of the date such enrollment change request is submitted to the Plan.

The effective date of such enrollment or disenrollment shall be in accordance with the provisions of the COC, and as defined in Addendum 1 of this Contract.

2.4 Open Enrollment

Group shall designate an Open Enrollment Period of no less than thirty (30) days each calendar year. During this Open Enrollment Period, Eligible Employees and/or their Eligible Dependent(s) and Covered individuals may elect or change their Coverage according to the provisions within the COC.

2.5 Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”)

The Plan agrees to provide Benefits under this Contract for those Insureds who are eligible to continue coverage under COBRA. The Group remains solely responsible for all duties of the plan sponsor or plan administrator, including but not limited to notification of COBRA continuation rights, and billing and collection of Premium.

For purposes of COBRA administration, Group acknowledges and agrees:

1. That Group will notify the Plan within five (5) business days of the date (1) a Insured elects continuation coverage; or (2) the date that continuation coverage is terminated.
2. That the Plan will provide COBRA continuation coverage only for the time periods mandated by federal law, subject to all other provisions of the Contract.
3. That if Group fails to perform its responsibilities under federal law or this Contract, the Plan is not obligated to provide COBRA continuation coverage.

2.6 State Continuation Benefits

The Plan agrees to provide Benefits under this Contract for those Insureds who are eligible to continue coverage as outlined by applicable state law. The Group remains solely responsible for all duties of the plan sponsor or plan administrator, including but not limited to notification of state continuation rights, and billing and collection of Premium.

For purposes of state continuation benefits administration, Group acknowledges and agrees:

1. That Group will notify the Plan within five (5) business days of the date (1) a Insured elects continuation coverage; or (2) the date that continuation coverage is terminated.
2. That the Plan will provide state continuation coverage only for the time periods mandated by state law, subject to all other provisions of the Contract.
3. That if Group fails to perform its responsibilities under state law or this Contract, the Plan is not obligated to provide state continuation coverage.

3. Plan Obligations

3.1 Identification Cards

The Plan shall provide identification cards for each Covered individual.

3.2 Plan Materials

The Plan shall furnish to the Group, for each Subscriber, an EOC and/or COC, a Schedule of Benefits, and all applicable Riders and amendments, which set forth the Covered Services to which such Subscriber and their enrolled Dependent(s) may be entitled.

3.3 Certificate of Creditable Coverage

Certificates of Creditable Coverage will be issued, free of charge, by the Plan upon: (1) termination of any Subscriber or Subscriber's enrolled Dependent(s); (2) when a Subscriber or Subscriber's enrolled Dependent(s) becomes entitled to elect State Continuation or COBRA continuation coverage; or (3) when State Continuation or COBRA continuation coverage ceases. The Plan shall mail to the Subscriber a Certificate of Creditable Coverage for each terminated Insured.

4. Premiums

4.1 Payment

The amount of each Premium payment due from Group shall be the aggregate of the several amounts with respect to each Covered individual enrolled hereunder at the time such Premium payment falls due; and the amount so payable with respect to each Covered individual of Group shall be determined according to the benefits for which the Covered individual is enrolled and the rates applicable to such benefits.

Such Premium payments shall be made on or before the first day of the month, for each month in which Coverage is in force, with respect to all persons enrolled hereunder at the time such Premium payment falls due. Coverage for a newly enrolled individual or for additional or increased benefits for an existing Covered individual who becomes effective on or before the [fifteenth (15) day] of any month shall be provided on the basis of a Premium payment for a full month. Whereas, Coverage for a newly enrolled individual, or for additional or increased benefits for an existing Covered individual who becomes effective after the [fifteenth (15th) day] of any month shall be provided for the balance of such month without Premium payment therefore.

The Plan may impose a service charge of \$20 when payments are refused and/or returned by the Group's financial institution, such as, but not limited to, an account with non-sufficient funds available.

4.2 Grace Period

This Contract has [a thirty-one (31) day] [no] grace period for the payment of any Premium falling due [after the first Premium]. If the required Premium payment is not paid on or before the date it is due[, it must be paid during the grace period]. [During the grace period, this Contract will stay in force, but the Plan may suspend Group claims. In no case shall the Plan be held liable for claims incurred during a grace period unless appropriate dues or premiums are received by the Plan during such grace period.] Failure to pay Premiums when due does not constitute notification of intention by Group to terminate the contract.

4.3 Change of Premium Payment

The Plan reserves the right to adjust the Premium due, after a thirty-one (31) day prior written notice on the first anniversary of the Effective Date of this Contract or on any monthly due date thereafter, or on any date the provisions of this Contract are amended. Contract amendments may be caused by, but not limited to, statutory changes mandating mid-year benefit plan changes, or changes in benefits or enrollment criteria requested by the Group.

1. The Plan also reserves the right to change the Premium due, retroactive to the effective date of coverage, if a material misrepresentation relating to health status or enrollee coverage resulted in an initial, lower Premium rate.

Any adjusted Premiums shall apply to all future Premiums as well as the one then due. If Premiums are payable on a basis other than monthly, and if a change occurs during a Premium payment period which affects Premiums, a pro rata charge or credit will be made for such change on the next closest Premium due date

5. Renewal of Contract

This Contract shall automatically renew on the Contract Year anniversary for successive periods of 12 consecutive months, unless terminated by either party pursuant to this Contract. At least [thirty-one (31)] days prior to the Contract Year anniversary date, the Plan shall provide written notice to the Group of the terms and conditions under which the Plan will renew the Contract. Such terms and conditions may include a change in Premium or a change in the benefit plan offered for Coverage. If the Group fails to notify the Plan at least [fifteen (15)] days prior to the Contract Year anniversary date of its intention to terminate this Contract at the end of the Contract Year, the Contract shall automatically renew according to the terms and conditions stated within the notice of renewal.

6. Term and Termination

6.1 Term

This Contract shall remain in effect for an initial period of 1 year from the Effective Date and shall automatically renew pursuant to Section 5, Renewal of Contract, as stated above.

6.2 Termination by Group.

Upon prior written notice to the Plan, the Group may terminate this Contract outside of the Contract Year anniversary date upon occurrence of any of the following events. If termination occurs under this provision, Group agrees to provide written notice to each Subscriber enrolled under the Plan.

1. Amendment or Modification to Contract. In the event the Plan amends or modifies this Contract, including the terms and conditions of Coverage hereunder, and such amendment or modification is unacceptable to Group, the Group may terminate this Contract upon [thirty-one (31)] days prior written notice.
2. Material Breach of Contract. In the event the Plan materially breaches any of the terms and provisions of this Contract, the Group may terminate this Contract upon [sixty (60)] days written notice, provided however, that the

Plan has not substantially cured the breach during the [sixty (60)] day notice period.

3. Without Cause. The Group may terminate this Contract without cause upon [ninety (90)] days prior written notice to the Plan, specifying the basis for said termination. Failure to pay Premiums when due does not constitute notification of intention by Group to terminate the contract.

If this Contract is terminated by Group for any reason, the Group shall continue to be liable for any Premium due prior to such notice of termination and during the time Coverage is in force.

6.3 Termination by Plan.

Upon prior written notice to the Group, the Plan may terminate this Contract upon occurrence of any of the following events.

1. Premium payment required to be made by the Group is not received by the required due date[, subject to the [thirty-one (31)] day grace period]. The Group shall not be permitted to unilaterally reinstate Coverage through the submission of Premium payments after the date on which termination under this provision occurs. Groups requesting reinstatement of coverage after being terminated for non-payment of Premiums may be assessed, at the discretion of the Plan, a reinstatement fee of [\$100]. The Plan reserves the right to determine whether to consent to reinstatement of the Group.
2. Upon [thirty-one (31)] days written notice, in the event that the Group fails to meet the Plan's continued underwriting standards, participation requirements or contribution standards as defined in Addendum 2.
3. Upon [thirty-one (31)] days written notice, if the Group performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact, or material violation of the terms of this Contract, or the EOC and/or COC. Notwithstanding the previous sentence, however, a [thirty-one (31)] day notice of termination is not required under this provision if the termination is based on fraud or misrepresentation in the Application for Group Benefits or other enrollment documents, and failure by the Plan to provide such notice shall not invalidate termination of this Contract.

Failure of the Plan to provide written notice to Group shall not invalidate termination of Coverage for the following:

1. Failure to pay the required Premium payments when due and in accordance with the Grace Period; or
2. Fraud or misrepresentation in the application or enrollment documents when found within the first two years that coverage is in force.

The termination of this Contract, in accordance with Sections 6.2 and 6.3, shall not prejudice any claim incurred prior to the date of such termination. The Group shall be responsible for the payment of all Premium fees due through the date on which Coverage ceases.

7. General Provisions

7.1 Contractual Relationships

This Contract is part of the EOC and/or COC as if fully incorporated into the Agreement, and any direct conflict between this Contract and EOC and/or COC will be resolved according to the terms that are most favorable to the Insured.

7.2 Choice of Law

This Contract will be administered under the laws of the State of Arkansas.

7.3 Conformity With Law

If the provisions of this Contract do not conform to the requirements of any state or federal law that applies to this Contract, then this Contract is automatically changed to satisfy the minimum requirements of that law.

7.4 Clerical Error

Clerical error shall not deprive any individual of Coverage under the EOC or create a right to additional benefits. Upon discovery of a clerical error, any necessary adjustment in Premiums shall be made. However, the Plan shall not grant any such adjustment in Premiums or coverage to the Group if the date of coverage is more than 60 days prior to the date we receive notification of such clerical error.

7.5 Severability

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

7.6 Valid Amendment

Any amendment to this Contract shall be in writing and must be approved and executed by the President or a duly designated officer of the Plan. The Plan may amend this Contract, or any provision thereof, subject to the approval by the appropriate regulatory agencies, at any time upon thirty-one (31) days prior written notice to the Group. Payment of Premium beyond the effective date of the amendment constitutes the Group's consent to such amendment.

7.7 Notice

Any notice under this Contract shall be given by way of United States mail, postage prepaid, addressed as follows:

1. If to Subscriber: to the last known address, provided by the Group or Subscriber, actually delivered to the Plan.
2. If to the Group: to the latest address provided by the Group to the Plan.
3. If to the Plan: Coventry Health Care of Kansas, Inc., 8320 Ward Parkway, Kansas City, MO 64114

7.8 Waiver

The failure of the Plan or the Group to enforce any provision of this Contract 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 Contract shall not be deemed or construed to be a waiver of such default.

7.9 Resolution of Disputes

If a dispute between Plan and Group arises out of or is related to this Contract, the parties to the dispute shall meet and negotiate in good faith to attempt to resolve the dispute. If, after [30 days] such dispute is not resolved, the aggrieved party shall send written notice to the other party of the precise nature of the dispute. If after a dispute has arisen, an appraisal or arbitration may take place if the Group and the Plan fail to agree on the amount of the loss. However, an appraisal or arbitration will take place only if both the Group and the Plan agree, voluntarily, to have the loss appraised or arbitrated.

7.10 Addenda To This Contract

The following documents are hereby incorporated by reference as if fully set forth herein.

- Addendum 1 - Employer Group Application
- Addendum 2 - Plan Type Selection, and Rate Addendum
- Addendum 3 - HIPAA 504(f) Certification
- Addendum 4 - Evidence of Coverage and/or Certificate of Coverage
- Addendum 5 - Schedule of Benefits
- Addendum 6 - Applicable Riders

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by duly authorized representatives this _____ day of _____, 20__.

**GROUP:
CO.**

COVENTRY HEALTH & LIFE INSURANCE

By: _____

By: _____

Name: _____

[Michael G. Murphy]
Authorized Signatory

Title: _____

Date: _____

Date: _____

ADDENDUM 1

[Group Application Form to be Inserted]

ADDENDUM 2

[RATE CHART TO BE INSERTED BY UNDERWRITING/MARKETING]

Participation and Underwriting Requirements

[INSERT FROM UNDERWRITING]

ADDENDUM 3

Certification to Group Health Plan, HMO or Health Insurance Issuer

This Certification is intended to comply with the Health Insurance Portability and Accountability Act of 1996's ("HIPAA") Privacy Rules ("the Rule"), specifically 45 CFR 164.504(f) and 65 Fed. Reg. 82508 (December 28, 2000). This certification allows the Group ("Plan Sponsor") and the Plan to exchange Protected Health Information ("PHI"), as such term is defined within the Rule, for plan administration functions without obtaining individual consent or authorization.

WHEREAS The Group is the sponsor of a group health plan for its employees and their dependents; and

WHEREAS Plan Sponsor's group health plan is a "health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

WHEREAS The Plan provides health insurance coverage to the participants and beneficiaries in the Plan Sponsor's group health plan; and

WHEREAS The Plan and Plan Sponsor desire to exchange health information protected under HIPAA or PHI for purposes related to administration of the group health plan;

THEREFORE BE IT RESOLVED, that Plan Sponsor hereby certifies to the Plan the following, as required by Section 45 CFR 164.504(f) of HIPAA:

The plan documents that govern Plan Sponsor's group health plan have been amended to incorporate the following provisions and Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law;
2. Ensure that any agents, including subcontractors, to whom it provides PHI received from Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;
3. Not use or disclose PHI for employment-related actions and decisions;
4. Not use or disclose PHI in connection with any other benefit or employee related plan of Plan Sponsor;
5. Report to the Plan's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses and disclosures provided for;
6. Make PHI available to an individual based on HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
8. Make available the information required to provide an accounting of disclosures;
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the health plan's compliance with HIPAA;
10. Ensure that the adequate separation between the group health plan and the Plan Sponsor are established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
11. If feasible, return or destroy all PHI received from the health plan that Plan Sponsor maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

ADDENDUM 4

[Certificate of Coverage to be Inserted]

ADDENDUM 5

[Schedule of Benefits to be Inserted]

ADDENDUM 6

[Riders to be Inserted]



[8320 Ward Parkway];
[Kansas City, MO 64114]

Risk Appraisal Questionnaire

This questionnaire is designed to provide information specific regarding your group and will be used in evaluating the risk characteristics to more accurately establish rates, benefits and eligibility rules.

THIS IS NOT AN APPLICATION FOR GROUP COVERAGE.

Employer Information

Company Name, including D.B.A:				Federal Tax ID #:	
<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other	No. Years in Business	
Standard Industry Code (SIC)		Nature of Business		Effective Date:	
Physical Address (if different)		City		State	Zip

Total Employees:		Do any employees, to be covered under this Plan, live and work in these areas?	Retirees Covered		
_____ Full Time	_____ Part Time		_____ Seasonal	<input type="checkbox"/> No	<input type="checkbox"/> If Yes, Are they Covered?
_____ Retiree	_____ COBRA		_____ Union	<input type="checkbox"/> Age 65 & older	<input type="checkbox"/> Under age 65
Total Eligible: _____ Waivers: _____			<input type="checkbox"/> Dependents of Retirees		
Employer Contribution:		<input type="checkbox"/> Texas	<input type="checkbox"/> Oklahoma	<input type="checkbox"/> KC Metro – KS	<input type="checkbox"/> KC Metro – MO
_____ Employee	_____ Dependent	<input type="checkbox"/> Wichita			

Health Information

Please provide the answers to the following health conditions as they pertain to all eligible employees and/or covered dependents, including COBRA beneficiaries, individuals on FMLA, Work Comp, or Disability Leave – with in the last [24 – 48] months. Provide details in the space provided below. Use back, if necessary.

Condition	Yes	No	Condition	Yes	No
Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder disease or dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, emphysema or other lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes – circle treatment (diet, oral meds or insulin)	<input type="checkbox"/>	<input type="checkbox"/>	(circle one) A, B, C, D	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or other tumors	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis, Muscular Dystrophy, Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, Mental, or Pervasive (autism) disorders	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant (planned or past 10 years)	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of the spine, back, joints, or bones	<input type="checkbox"/>	<input type="checkbox"/>	HIV, AIDS, or Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease, angina	<input type="checkbox"/>	<input type="checkbox"/>			

Details of condition (do not list employee names):

Employer Statement

I understand that this a Risk Appraisal for quoting purposes only. I further understand any proposal derived from this information is not a final offer of coverage and subject to additional underwriting upon receipt of a completed Application for Group Benefits. Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") reserves the right to retroactively adjust the rates and/or withdraw any proposal provided, upon submission of full application for coverage including Application for Group Benefits and any other information requested.

Name/Title (please print)	Authorized Signature	Date
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Employer Information

Company Name, including D.B.A:				Federal Tax ID #:	
<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other	No. Years in Business	
Standard Industry Code (SIC)		Nature of Business:			
Corporate Address:		City	State	Zip	
Physical Address (if different)		City	State	Zip	
Mailing Billing Address (if different)		City	State	Zip	
Billing Contact Person	Phone	Fax	Email		
Benefits Contact Person	Phone	Fax	Email		
Name of Authorized Signatory & Title	Phone	Fax	Email		

Benefits Requested

Effective Date Requested: _____ Products Requested: Medical Pharmacy Dental Coventry Consumer Choice (C3)

Medical: (1) Plan: _____ Deductible: _____ Copay: _____ Coinsurance: _____ OOPM: _____
 (2) Plan: _____ Deductible: _____ Copay: _____ Coinsurance: _____ OOPM: _____
 (3) Plan: _____ Deductible: _____ Copay: _____ Coinsurance: _____ OOPM: _____

Deductible Accumulates on a Calendar Year basis or Contract/Plan Year basis or Other: _____

Pharmacy: QHDHP Super Joe **OR** Tier 1: _____ Tier 2: _____ Tier 3: _____ Tier 4: _____ ; Mail Order: x 1 ½ x 2 x 2 ½ x 3

Deductible Applies to: All Tiers **OR** ONLY to Tier: 1 2 3 4 Deductible Amount: _____

Dental: Plan Name: _____ Plan Code: _____ Rates: EE: _____ EE+SP _____ EE+CH _____ F: _____
 * Employer must contribute at least 50% of employee premium. For contribution amounts less than 50%, the rates will be increased to voluntary levels.

Coventry Consumer Choice (C3): FSA (Medical Dependent Care) HSA HRA POP

Contract Information

Coverage Begins	Coverage Terminates	Employee Class Covered
<input type="checkbox"/> First of month following:	<input type="checkbox"/> End of Month	<input type="checkbox"/> Full-time* <input type="checkbox"/> Part-time
<input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	<input type="checkbox"/> Date of Termination	* Statutory minimums required.
<input type="checkbox"/> Date of Hire		
Retirees Covered <input type="checkbox"/> No <input type="checkbox"/> If Yes, Are they Covered?	<input type="checkbox"/> Under age 65 <input type="checkbox"/> Age 65 & older	<input type="checkbox"/> Dependents of Retirees
Other Eligibility criteria, not listed above	Billing Options:	Do any employees, to be covered under this Plan, live and work in these areas?
	<input type="checkbox"/> Separate bill by Class	<input type="checkbox"/> Texas
	<input type="checkbox"/> Combined bill	<input type="checkbox"/> Oklahoma
	<input type="checkbox"/> Separate bill by location	<input type="checkbox"/> KC Metro – KS
		<input type="checkbox"/> KC Metro – MO
		<input type="checkbox"/> Wichita/Hutchinson

Contribution		Contribution Percentage	
Class Description	Waiting Period (if different than above)	Employee	Dependent
Class I:			
Class II:			
Class III:			

Enrollment Information

Total number of employees during the proceeding Calendar Year:

Full-time*: _____ Part-time: _____ Seasonal: _____ Union: _____

* Statutory minimums required.

Total eligible for Coverage:	Number electing Coverage	Number employees terminated in last twelve (12) months?
------------------------------	--------------------------	---

Waiting periods **WILL / WILL NOT** be waived at enrollment for full-time employees*? (* Statutory minimums required.)

Is the employer required to provide COBRA ?	Total number of COBRA or State Continuation Participants
---	--

List all Employees/Dependents on Continuation Leave. Include effective date and anticipated end date of Continuation Coverage.

Medicare Secondary Payer Rules *(add part-time and full-employees; part-time employees count as a full-time employee)*

Did the employer average at least 20 total employees last calendar year? Yes No

Did the employer average at least 100 total employees last calendar year? Yes No

In the past 36 months, has the Company or any affiliated entity filed for protection or operate under federal/state bankruptcy laws? Yes* No

In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliate to be put into bankruptcy? Yes* No

*If yes, please provide details:

Are all employees, including owners, covered by Worker's Compensation? Yes No If no, list employees not covered and indicate why.

List previous group health carriers for past five years. Include type of coverage (PPO, HMO, POS, etc)

List any employees not actively performing their duties full-time due to leave under FMLA, Disability or Worker's Compensation, or has a disabling illness, injury or pregnancy. Include disability, injury description, or pregnancy.

Please indicate below any employees and/or dependents who reside outside the states of Kansas, Missouri and/or Oklahoma.

Health Information

Please complete the following questions to the best of your knowledge. This information is necessary to evaluate your group's application. In order to protect the individuals involved, do not disclose the name of any employee or dependent. Provide the number of individuals and describe the situation.

Are you aware of any employee, dependent or COBRA or State Continuation (collectively referred to as Continuation) participants currently disabled?

Are you aware of any employee, dependent or Continuation participants who has had an organ transplant such as kidney, liver, heart or lung?

Employer Statement

I understand that this information may be verified by outside sources such as Equifax, or other investigative firms deemed appropriate for finalizing its approval. Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received indicates this information was incomplete, inaccurate or I have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact made in the application, and such information would have materially affected the rate calculation within a two-year period. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found. After coverage has been in force for two years, no statement except fraudulent statements I make affect the policy.

The Company represents that the information provided on this document is complete and accurate. The Company shall notify Health Plan promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. All coverage, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been thoroughly explained to eligible employees. The Company understands that Health Plan is relying on the information provided herein and consider it material to the insurance risk assumed by Health Plan.

Renewal premiums are based on the following factors: 1) the medical inflation rate; 2) changes in coverage; 3) changes to the demographic characteristics of the group, 4) changes in the geographic area in which Company resides; and 5) the actual or expected claims costs for your group as permitted by law. Premiums are guaranteed for one year and will not be changed mid-year except for: 1) statutory changes mandating a mid-year benefit change; 2) a material change in the nature of your business or industry; or 3) any changes in benefits or enrollment criteria requested by you.

This Application is subject to final approval by Health Plan and shall be based upon all information supplied by the group, the requested benefits, and any other information obtained from outside sources deemed appropriate. This Application shall be attached to and shall become part of the Group Master Contract (the "GMC").

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Name/Title (please print) Authorized Signature Date

Agent/Broker/Producer Statement

I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer.

Commission Split:

Agent/Broker/Producer Name	Agent/Broker/Producer TIN	Commission Percentage
Agent/Broker/Producer Name	Agent/Broker/Producer TIN	Commission Percentage
Agent/Broker/Producer] Name	Agent/Broker/Producer TIN	Commission Percentage

Selling Agent/Broker/Producer Name (please print) Signature Date

Office Use Only



Plan: HMO POS PPO QHDHP

Selection (Optional):
 Base Buy-up Buy-down Other:
 * Denotes required information

DO NOT WRITE IN MARGINS
Enrollment and Change Form
 [8320 Ward Pkwy, Kansas City MO 64114
 PH: 1-866-795-3995 - Fax: 1-866-287-6594]

Group Name:*	Group Number:	Employee Name:*	Effective Date / Date of Change:
--------------	---------------	-----------------	----------------------------------

- | | | | | | |
|---|-----------------------------------|--|---|--|---|
| <input type="checkbox"/> New Group | Add Dependent(s) | Cancel Dependent(s) only | Cancel All Coverage | COBRA / State Continuation | Reinstatement |
| <input type="checkbox"/> New Hire | <input type="checkbox"/> Marriage | <input type="checkbox"/> Marriage | <input type="checkbox"/> Terminate Employment | <input type="checkbox"/> Death | <input type="checkbox"/> Return from Layoff |
| <input type="checkbox"/> Declining Coverage (go to back page) | <input type="checkbox"/> Newborn | <input type="checkbox"/> Divorce | <input type="checkbox"/> Voluntary Withdrawal | <input type="checkbox"/> Termination | <input type="checkbox"/> Return from leave |
| <input type="checkbox"/> Name/Address Change | <input type="checkbox"/> Adoption | <input type="checkbox"/> Age Limit | <input type="checkbox"/> Leave/Layoff | <input type="checkbox"/> Reduction in Work Hours | <input type="checkbox"/> Rehire |
| <input type="checkbox"/> Dependent Address Change | <input type="checkbox"/> QMCSO | <input type="checkbox"/> Out of Service Area | <input type="checkbox"/> Out of Service Area | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Enrollment Error |
| <input type="checkbox"/> Telephone Change | <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Loss of Eligibility | <input type="checkbox"/> Other |

Section A – Employee/Policy Holder Information (PLEASE PRINT CLEARLY)

Last Name*	First Name*	Middle Initial	Email Address	Date of Hire*
Street Address*	City*	State*	Zip Code*	Home Telephone Number*
			Work Telephone Number	

Section B (PLEASE PRINT CLEARLY)

Is the Employee on a Leave of Absence? FMLA Worker's Compensation Disability Effective date of FMLA, COBRA or Continuation coverage:

Last Name, First Name, Middle Initial	Birth Date* MM/DD/YY	Sex M/F	Social Security Number*	Status*	Relationship to Employee	Dependent Address (if different than Employee Address)
Employee				<input type="checkbox"/> Active <input type="checkbox"/> On Leave <input type="checkbox"/> Retired	N/A	N/A
Spouse				<input type="checkbox"/> Common Law <input type="checkbox"/> Married* <input type="checkbox"/> Disabled		
Child				<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child				<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child				<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child				<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		

Other Medical Insurance Coverage? Yes No
 If yes, please list type: Commercial/Employer Group Individual Policy Medicare (Eligibility due to: Age 65 Disability Other **and** Coverage Includes: Part A Part B Part C Part D)
 What family members are covered? Self Spouse Child(ren) If not all, list: _____

Policy Holder: _____ **Insurance Provider:** _____ **Policy Effective Date:** _____

* when Dependent Child coverage is required by a court decree (please provide court decree). You must submit affidavit with Enrollment if indicating marriage under Common Law. Please also submit any divorce decree or family court order, if applicable, so that order of benefit Coordination may be determined promptly to prevent any delay in claim processing/payment.

Agreement and Authorization

Unless waiving coverage below, by signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers, except for those questions in Section D, will be used to determine eligibility for coverage. If I have, on behalf of myself and my Dependents, performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

Plans offered by Coventry Health and Life Insurance Company are underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Kansas, Inc.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I have read and agree to the statements above.

Employee Signature	Employee Printed Name	Date
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INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARDS(S) AND MAY RESULT IN DENIED CLAIMS

Declination of Coverage

I Waive Medical Coverage for: Myself (Employee) & Any Eligible Dependents Spouse Child(ren)

Reason waiving coverage: Covered by other group medical insurance. List insurer: Other reason (please explain):

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends, or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period.

Employee Signature	Employee Printed Name	Date
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Employee Enrollment / Health Statement and Declination of Coverage Form

Note: * Denotes required field or section

Office Use Only
Group No.:

i. Employee Information		*Last Name	*First Name	MI	Home Phone ()
Address			*City, State	*Zip	County
Group/Employer Name		*Occupation	*Hire Date	*Work Phone ()	Email address
Effective Date of Coverage	*Employer Group and Sub-Group Number	<input type="checkbox"/> FMLA <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation			Effective Date:

ii. Declination of Coverage (If declining coverage, please complete this section, skip sections C and D, then sign and date the back of this form.)

Waive Medical Coverage for: Employee & Any Eligible Dependents Spouse Child(ren)

Reason waiving coverage: Covered by other group medical insurance. List insurer _____ Other reason (please explain): _____

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period.

iii. Coverage Selection Employee Only EE +Spouse EE + Child(ren) EE + Family

iv. Dependent Member Information* Is the Employee on a Leave of Absence? FMLA Worker's Compensation Disability or Retired

*Last Name, First Name, MI	*Gender	*Birth date	*Height	*Weight	*Social Security Number	*Status	Relationship to Employee	*Dependent Address if different from Employee
Employee						<input type="checkbox"/> Active <input type="checkbox"/> On Leave <input type="checkbox"/> Retired	n/a	n/a
Spouse						<input type="checkbox"/> Common Law Married** <input type="checkbox"/> Disabled		
Child**						<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child**						<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child**						<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		

Other Medical Insurance Coverage? Yes No If yes, list type: Commercial/Employer Group Individual Policy Medicare (Eligibility due to: Age 65 Disability Other **and** Coverage Includes: Part A B C D) **What family members are covered?** Self Spouse Child(ren) If not all, list: _____

Policy Holder: _____ **Insurance Provider:** _____ **Effective Date:** _____

* For Dependent children eligible for Coverage under a Qualified Medical Child Support Order (QMCSO), you must submit the Medical Child Support order with Enrollment. You must submit affidavit with Enrollment if indicating marriage under Common Law.

INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARD(S) AND MAY RESULT IN DENIED CLAIMS

v. Health Information* (for rating purposes only). Please answer all questions fully and accurately for yourself and your dependent(s) unless you are waiving all coverage. You must give full details for all "yes" questions. If needed, please date and sign additional pages. Incomplete answers could delay the decision on your request for coverage. You should not include any of your and/or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic service, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

- | | |
|--|--|
| 1. Is anyone <u>currently</u> taking medication or receiving any medical treatment of any kind? List below. <input type="checkbox"/> Y <input type="checkbox"/> N | 4. Has anyone smoked cigarettes or used tobacco products within the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. Within the past 5 years, have you or your dependents been advised to have surgery, treatment or tests NOT YET performed? <input type="checkbox"/> Y <input type="checkbox"/> N | 5. Are you or any family member pregnant? (Indicate expected delivery date and any complications.) Due date: <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3. Has anyone been to the emergency room or hospitalized within the past 5 years? <input type="checkbox"/> Y <input type="checkbox"/> N | 6. Has anyone had an organ transplant, in treatment, or on a waiting list for an organ transplant? <input type="checkbox"/> Y <input type="checkbox"/> N |

Has anyone within the past 10 years, had any diagnosis or treatment for any of the following:

- | | |
|---|---|
| 7. Chest pain or pressure, heart trouble, heart attack, heart murmur, rapid, slow or irregular heart beat? <input type="checkbox"/> Y <input type="checkbox"/> N | 16. Mental or nervous disorders (including emotional or behavioral disorders)? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 8. High blood pressure, stroke or other circulatory problems? <input type="checkbox"/> Y <input type="checkbox"/> N | 17. Cancer, tumors, cysts, polyps or growths of any kind? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 9. Epilepsy, seizures, convulsions or frequent headaches? <input type="checkbox"/> Y <input type="checkbox"/> N | 18. Rashes or any other skin condition? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 10. Pancreas, liver, spleen or gallbladder problems? <input type="checkbox"/> Y <input type="checkbox"/> N | 19. Arthritis, gout or joint disorder? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 11. Prostate, kidney or bladder problems, or blood in the urine? <input type="checkbox"/> Y <input type="checkbox"/> N | 20. Back, neck or spinal problems; bone, jaw or muscle condition? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 12. Any male or female reproductive organs, menstruation problems, abnormal pap test? <input type="checkbox"/> Y <input type="checkbox"/> N | 21. Disease or disorder of the eyes, ears, nose, mouth, throat, or sinuses? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 13. Venereal disease (such as gonorrhea, syphilis, genital herpes, chlamydia) or other infectious disease? <input type="checkbox"/> Y <input type="checkbox"/> N | 22. Blood disorders; diabetes, or disease or disorder of the thyroid, breast or other glands? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 14. Bronchitis, tuberculosis, asthma, emphysema, pneumonia, or other respiratory or lung problems? <input type="checkbox"/> Y <input type="checkbox"/> N | 23. Alcohol or drug problem, dependency, abuse, overdose or drug reaction? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 15. Crohn's disease, ulcers, colitis, intestinal disorders, hemorrhoids, proctitis, hernia, other digestive problems? <input type="checkbox"/> Y <input type="checkbox"/> N | 24. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the HIV virus? <input type="checkbox"/> Y <input type="checkbox"/> N |

Please give full details for all "Yes" questions (above). If necessary, attach additional pages. Please date and sign any additional pages.

Question #	Covered Person's Name	Diagnosis and Dates of Treatment	Medications	Doctor's Name

Agreement and Authorization: Unless waiving coverage as listed in Section B, by signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law. I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law. I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers, except for those in Section D, will be used to determine eligibility for coverage. If I, on behalf of myself and my Dependents, engage in gross misbehavior, intentional fraud or the making of intentional misrepresentation of material fact in applying for or seeking any benefits through the Health Plan, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

PPO Plans are underwritten by Coventry Health and Life Insurance Company and administered by [Coventry Health Care of Kansas, Inc.]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I have read and agree to the statements above.

Employee Signature _____ **Employee Printed Name** _____ **Date** _____

SERFF Tracking Number: CVKS-127187464 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 48898
 Company Tracking Number: CERTIFICATE OF COVERAGE, ET AL
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Certificate of Coverage, et al
 Project Name/Number: Certificate of Coverage, et al

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/28/2011
Comments:			
Attachment:			
Flesch.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/28/2011
Comments:	Applications for both Employer and Employee/Dependent are individually listed and identified under form schedule tab.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	06/28/2011
Bypass Reason:	Forms are not filed for PPACA compliance; however, these forms are drafted to be PPACA compliant.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter & Statement of Variability	Approved-Closed	06/28/2011
Comments:	Page 18 of the certificate regarding Non-Participating Physician and Non-Participating Facility is in compliance with Bulletin 9-85. These provisions depict the disclosure of how "non-participating" provider fees are calculated. Bulletin 9-85, "2. The difference in benefit levels, i.e., deductibles and co-pay provisions, etc, offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person in contravention of Ark. Stat. Ann. §66-3703," is applicable to the Schedule of Benefits which depicts the differences in benefit level, of which Coventry certifies it will be in compliance.		

SERFF Tracking Number: CVKS-127187464 *State:* Arkansas
Filing Company: Coventry Health and Life Insurance Company *State Tracking Number:* 48898
Company Tracking Number: CERTIFICATE OF COVERAGE, ET AL
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Certificate of Coverage, et al
Project Name/Number: Certificate of Coverage, et al/

		Item Status:	Status Date:
Satisfied - Item:	PPACA Certification	Approved-Closed	06/28/2011
Comments:			
Attachment:			
	PPACA.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Redline Documents (Revisions)	Approved-Closed	06/28/2011
Comments:			
Attachment:			
	Redlines 2011 06 27.pdf		



Certification of Flesch Reading Ease

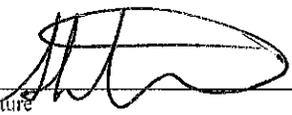
This document hereby certifies that the submitted documents, referenced below, comply with the provisions of the Life, Accident and Health Insurance Policy Language Simplification Act of Arkansas.

Any policy language is drafted to conform to the requirements of any federal law, regulation, or agency interpretation, including medical terminology, defined words, and any other policy language required by state law or regulation.

Riders, amendments, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

This certification shall accompany every and shall be signed by an authorized representative of the insurer certifying that the filing meets the minimum reading ease score on the test used.

Attested by:

Signature  _____

Director, Regulatory Compliance, Appeals, and Product Implementation
Title

<u>Form number(s) submitted:</u>	
CHL-AR-COC-011-05.11	Certificate of Coverage
CHL-AR-SOB-012-05.11	Schedule of Benefits
CHL-AR-RID-013-05.11	Pharmacy Rider
CHL-AR-RID-014-05.11	Hearing Aid Rider
CHL-AR-RID-015-05.11	TMJ Rider
CHL-AR-RID-016-05.11	Mental Health
CHL-AR-RID-017-05.11	Autism Rider
CHL-AR-RID-018-05.11	Obesity Services Rider
CHL-AR-RID-019-05.11	ACO/HPN Network Rider
CHL-AR-GMC-020-05.11	Group Master Contract
AR-RAQ-ER-05.11	Employer Group Risk Appraisal Questionnaire
AR-APP-CF-05.11	Change Form/Large Group Enrollment Form
AR-APP-ER-05.11	Employer Group Application
AR-APP-HS-05.11	Health Statement/Enrollment Form

PPACA Uniform Compliance Summary

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

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

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

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

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Coventry Health & Life Insurance Company	1137-95489	CVKS-127187464	CHL-AR-COC-011-05.11 CHL-AR-SOB-012-05.11 CHL-AR-RID-013-05.11 CHL-AR-RID-014-05.11 CHL-AR-RID-015-05.11 CHL-AR-RID-016-05.11 CHL-AR-RID-017-05.11 CHL-AR-RID-018-05.11 CHL-AR-RID-019-05.11	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

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

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

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

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

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

PPACA Uniform Compliance Summary

Reset Form

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

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
-----	----------	-----------------	---------------	-------------------

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

PPACA Uniform Compliance Summary

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

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

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

PPACA Uniform Compliance Summary

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

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

Eligibility & Termination

Eligibility

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

- Be an Eligible Employee of the Employer Group, and eligible to participate equally in any alternate health benefits plan offered by the Employer Group by virtue of his/her employment status;
- Meet any eligibility criteria specified by the Employer Group and approved by the Plan, including, without limitation, the criteria set forth in the Group Master Contract; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

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

Be the lawful Spouse of the Subscriber or be the child of the Subscriber or the Subscriber's Spouse including:

- Children up to their twenty-sixth (26) birthday who are either the birth children of the Subscriber or the Subscriber's Spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
- Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Subscriber 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;

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Deleted: the onset of such incapacity occurred before twenty-six (26), proof of such incapacity is furnished to the Plan by the Subscriber with-in thirty-one (31) days after the child reaches the limiting age and annually thereafter

Retirees

A Retiree or Retiree's Spouse who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B Coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement.

Change of Employer Group's Eligibility Rules

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

SERFF Tracking Number: CVKS-127187464 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 48898
 Company Tracking Number: CERTIFICATE OF COVERAGE, ET AL
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Certificate of Coverage, et al
 Project Name/Number: Certificate of Coverage, et al/

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)
05/25/2011	Form	Certificate of Coverage	06/27/2011	CHL-AR-COC-011-05.11.pdf (Superseded)
05/26/2011	Supporting Document	Cover Letter & Statement of Variability	06/27/2011	Coverletter 2011 05 26.pdf (Superseded)



Health Care Benefits

Arkansas

PREFERRED PROVIDER ORGANIZATION (“PPO”)

CERTIFICATE OF COVERAGE (“COC”)

IMPORTANT NOTICE

THIS COC, THE SCHEDULE OF BENEFITS AND ALL ATTACHED RIDERS/ENDORSEMENTS SHOULD BE READ IN THEIR ENTIRETY.

You have the full freedom of choice in the selection of any duly licensed health care professional. This COC has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers are used. Please consult this Certificate of Coverage, 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]



Welcome to Coventry Health & Life Insurance Company!

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

As a Coventry Health & Life Insurance Company Insured, it is important that You understand the way Your Plan operates. This COC contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials so that You are aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com any time for additional information.

We look forward to serving You.

Sincerely,

[Michael Murphy]

Chief Executive Officer

Table of Contents

Coventry Health & Life Insurance Company
Certificate of Coverage

The Agreement between **Coventry Health & Life Insurance Company** (hereafter called the “Plan”) and You and between the Plan and Your Dependents and is made up of:

- This Certificate of Coverage (“COC”) and Amendments;
- Application Form;
- Applicable Riders;
- Provider Directory; and
- Schedule of Benefits.

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

THIS AGREEMENT SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Agreement and understanding Your relationship to the Plan, You can be an informed participant. You should keep this COC in a safe place for Your future reference. Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement will appear capitalized because they have special meaning and are defined for You in Section 1. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Agreement may be amended. When that occurs, the Plan will provide an Amendment or new COC to You for this Agreement.

You may examine a copy of this COC, the Group Master Contract, the Group Application for Benefit Offerings, individual Subscriber Employee Enrollment/Change Form, Amendments, Schedules and Riders at the office of the Employer Group during regular business hours.

The Plan is responsible for making benefit determinations in accordance with the Group Master Contract, this COC and the Plan’s agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim for payment or Pre-Certification of a recommended service, the Member may request reconsideration of that decision through the Plan’s Member Complaint and Grievance Procedure described in this COC.

Definitions

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

“Activities of Daily Living”

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

“Acute”

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

“Administrative Appeal”

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; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Insured and the Plan.

“Alternate Facility”

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:

- 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.

“Amendment”

Any attached written description of additional or alternative provisions to the COC and/or this COC. Amendments are effective only when Authorized in writing by the Plan and are subject to

Definitions

all conditions, limitations and exclusions of the COC except for those which are specifically amended.

“Ancillary Provider”

A Provider who is not licensed as a Physician or a Hospital.

“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.

“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 Health Insurance Portability and Accountability Act (“HIPAA”) privacy purposes.

“Benefit Maximum”

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for the Insured in any one Benefit Year. Once a Benefit Maximum is met, no more Covered Services will be provided during the same Benefit Year.

“Benefit Year”

The period of time during which the total amount of annual benefits under Your Coverage is calculated. Your COC may be issued on either a Calendar Year or Contract Year. Please call the customer service number on the back of your ID card to obtain information about Your Benefit Year.

“Calendar Year”

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

“Chronic Condition”

A health condition that is continuous or persistent over an extended period of time.

“Coinsurance”

Cost-sharing arrangement in which the Insured pays a specified percentage of the cost for a Covered Service.

“Coinsurance Maximum”

The annual limit of a Insured’s coinsurance payments for Covered Services, as specified in the Schedule of Benefits”

“Complaint”

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

“Confinement” and “Confined”

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

“Contract Year”

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

Definitions

Date and each subsequent anniversary.

“Copayment”

Cost-sharing arrangement in which the Insured pays a specified dollar amount as their share of the cost for a Covered Service.

“Cosmetic Services and Surgery”

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

“Coverage” or “Covered”

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

“Covered Services”

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

“Custodial Care”

Care is considered custodial when it is primarily for the purpose of helping the Insured 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 the Insured who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Insured, 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.

“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 COC.

“Dental Services”

Services primarily for the prevention, diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

“Dependent”

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

“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 an agreement with a Designated Transplant Network Facility to render Medically

Definitions

Necessary and medically appropriate services for Covered transplants.

“Durable Medical Equipment”

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

“Elective Abortion”

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Insured upon whom the abortion is performed.

“Eligible Employee”

An individual employed by the Employer Group who meets all the eligibility requirements specified in the Agreement including, but not limited to, this COC, the Group Application for Benefit Offerings, and the Group Master Contract.

“Eligible Expenses”

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

“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 the Insured’s health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part; or
- Inadequately controlled pain.

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; or
- Vaginal bleeding during pregnancy.

The Insured may seek medical attention from a Hospital, Physician’s office or some other Emergency facility.

“Emergency Services”

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this COC.

“Employer Group”

The employer or other legally constituted group with whom the Group Master Contract is made.

“Employee Enrollment/Change Form”

Definitions

Your application for enrollment in the Plan.

“ERISA”

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

“Experimental or Investigational”

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

- Any drug not approved for use by the Federal Food and Drug Administration (“FDA”); any drug that is classified as an Investigational New Drug (“IND”) by the FDA; or any drug that is proposed for off-label prescribing. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval.
 - Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

“FDA”

Federal Food and Drug Administration.

“Group Master Contract (“GMC”)

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

“Group Effective Date”

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

“Group Enrollment Period”

The period of time occurring at least once annually during which time any Eligible Employee may enroll with the Plan.

“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.

“Home Health Care Services”

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

“Hospice”

An organization or entity whose primary purpose is to furnish medical services and supplies only to patients who are considered to be terminally ill. The Plan has the right to determine whether a facility is a Hospice facility.

Definitions

“Hospital”

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; 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.

“Illness”

Physical ailment, or disease. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

“IND”

Investigational New Drug.

“Infertility”

Any medical condition causing the inability or diminished ability to reproduce.

“Infertility Services”

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

“Injury”

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

“Inquiry”

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

“Insured”

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions and for whom, or on whose behalf, Premiums have been received and accepted by the Plan.

“Institutional Review Board (“IRB”)”

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

“Limiting Age”

The maximum age a non-Spouse Dependent can be to maintain eligibility under the terms of the Plan, and as defined in the Group Master Contract.

“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.

“Material Misrepresentation”

Medical or other information not disclosed on the application, or as it relates to Covered Services, which, if it had been disclosed, would have affected the acceptance of coverage, benefits offered or provided and/or Premium charged.

“Maternity Services”

Definitions

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

“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 Pre-Certification programs.

“Medically Necessary/Medical Necessity”

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

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

“Medical Necessity Appeal”

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.

“Medicare”

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

“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.

“Mental Illness” or “Mental Health”

Those conditions classified as “mental disorders” in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

“NIH”

National Institutes of Health.

“Non-Participating Provider”

Definitions

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

“Officer”

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

“Orthotic Appliances”

Orthotic Appliances correct or support a defect of a body form or function.

“Out-of-Pocket Maximum”

The annual limit of an Insured’s payments for Covered Services, as specified in the Schedule of Benefits.

“Participating Provider”

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Insured.

“Peer-Reviewed Medical Literature”

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

“Physician/Practitioner”

Means 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.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan’s obligation under the COC, 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.

“Plan”

Coventry Health & Life Insurance Company.

“Post-Service Appeal”

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

“Pre-Certification”

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

“Preventive Services”

Shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered available on our website at [\[www.chckansas.com\]](http://www.chckansas.com) or will be mailed to you upon request.

“Pre-Existing Condition”

Any condition for which You received medical advice, diagnosis, care, treatment or recommended treatment from an individual licensed or similarly authorized to provide such

Definitions

services under applicable state law within the twelve (12) month period prior to the effective date of your Coverage. A condition may be defined as Pre-Existing whether physical or mental, and regardless of the cause of the condition. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition relating to such information.

“Pre-Existing Condition Exclusion Period”

The period of time for which Covered Services are excluded for a Pre-Existing Condition. The Pre-Existing Condition Exclusion Period begins on Your Effective Date of Coverage.

“Pre-Service Appeal”

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

“Premium”

The monthly fee required from Insured in accordance with the terms of the COC.

“Prosthetic Devices”

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

“Provider”

A Physician, Hospital, 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.

“Reconstructive Surgery”

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

“Retiree”

A former Eligible Employee of the Employer Group who meets the Employer Group’s definition of retired employees to whom the Employer Group offers Coverage under this COC and Group Master Contract.

“Rider”

An Amendment that modifies Covered services and is attached to the COC. Services provided by a Rider may be subject to payment of additional Premiums.

“Self-Injectables”

Injectable Prescription Drugs as specified in the Plan’s formulary list, that are commonly and customarily administered by the Insured according to clinical guidelines used by the Plan.

“Semi-private Accommodations”

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private

Definitions

Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.

“Special Enrollment Period”

The period after the regular Group Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of COC.

“Spouse”

A Subscriber’s Spouse or eligible former Spouse as defined by applicable state law or court decree.

“Subscriber”

The Eligible Employee or Retiree who meets all the requirements as set forth in this COC and the Group Master Contract and who has elected the Plan’s Coverage for himself/herself and any eligible Dependents through submission of an Employee Enrollment/Change Form and for whom, or on whose behalf, Premiums have been received by the Plan.

“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.

“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.

“Therapeutic Injections and IV Infusions”

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

“Total Disability”

Complete inability of the Insured to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Insured to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. The disability of the Insured must require regular care and attendance by a Physician who is someone other than an immediate family member.

“Urgent Care”

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

“Urgent Care Appeal”

An Appeal for which a requested service requires Pre-Certification, 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 the Insured or the Insured’s unborn child; or (b) the Insured’s 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.

“Utilization Review”

Definitions

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, Pre-Certification, 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”

The Insured Covered under this COC.

Using Your Benefits

Identification (“ID”) Card

Every Insured will receive 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 an Insured 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 the ID card and in the Schedule of Important Numbers. 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 this COC.

Health Services Rendered By Participating Providers

An Insured has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the COC. Coverage for services described in this COC and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses of this COC. Participating Providers are contractually obligated to file all claims for You.

It is the Insured’s 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. The Insured is responsible for verifying the status of the Provider by contacting the Customer Service Department or by checking the Plan’s website at [www.chckansas.com].

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

Notice of Claim

The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits. A Non-Participating Provider may or may not complete and file the claim form for You. Written notice of claim must be submitted to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the COC, or as soon thereafter as is reasonable.

Claim Forms

You may obtain a Non-Participating claim form from the Plan’s Customer Service Department within fifteen (15) days from the date the Plan receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss,

within the time fixed for filing a claim.

Proofs of Loss

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 Insured's failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of legal capacity of the claimant, when You submit proof of loss to the Plan more than twelve (12) months from the date services were provided by the Non-Participating Provider.

Processing of the Filed Claim

We make claim payment decisions based on the information provided on the submitted claim form. We make every effort to process claims upon receipt of the Proof of Loss. All Covered Services payable under the COC shall be paid not more than thirty (30) days after receipt of the completed claim form, and subject to the Proof of Loss provision of this COC. If We deny all or part of Your claim, We will send You an Explanation of Benefits form or a letter explaining why it was denied under the terms of the COC. We will also notify You if additional information is necessary to process the claim.

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 must 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 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 prior year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession 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 prior year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the prior year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the Plan's Average Wholesale Price ("AWP"). Payment for anesthesia services will be 200% of the prior year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DME POS") will be at the prior year DME POS ceiling limit. Payment for Laboratory services will be at the prior year 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.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Insured’s responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided to You. To request a copy contact the Plan’s Customer Service Department’s telephone number listed on Your ID card or by visiting the Plan’s website at [www.chckansas.com].

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this COC are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Insured.

Failure to obtain Pre-Certification will result in a reduction of benefits. To find out the amount of the penalty, please see the Schedule of Benefits. Any penalty applied does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Insured’s responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines medical necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a Material Misrepresentation or omission about the Insured’s health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Insured’s Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

An Insured may seek a second medical opinion or consultation from any Provider. An Insured should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Insured will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the COC.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to 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 contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan's Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. 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, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

How to Contact The Plan

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

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

Participating 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 COC, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the Insured or a person, other than the Plan or intermediary, acting on behalf of the Insured for services provided pursuant to this COC. This COC shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the EOC, 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 Coverage to You.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the COC. 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 COC. The Plan shall have the right, subject to Your rights under this COC, to interpret the benefits of this COC and attached Riders, and other terms, conditions, limitations and exclusions set out in the COC in making factual determinations related to the COC, its benefits, and the Insured; 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 COC must be in accordance with Eligibility & Termination of this COC. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan

Using Your Benefits

does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

Eligibility & Termination

Eligibility

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

- Be an Eligible Employee of the Employer Group, and eligible to participate equally in any alternate health benefits plan offered by the Employer Group by virtue of his/her employment status;
- Meet any eligibility criteria specified by the Employer Group and approved by the Plan, including, without limitation, the criteria set forth in the Group Master Contract; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

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

Be the lawful Spouse of the Subscriber or be the child of the Subscriber or the Subscriber's Spouse including:

- Children up to their twenty-sixth (26) birthday who are either the birth children of the Subscriber or the Subscriber's Spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
- Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Subscriber or the Subscriber's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before twenty-six (26), proof of such incapacity is furnished to the Plan by the Subscriber with-in thirty-one (31) days after the child reaches the limiting age and annually thereafter;

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Retirees

A Retiree or Retiree's Spouse who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B Coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement.

Change of Employer Group's Eligibility Rules

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

Eligibility & Termination

Persons Not Eligible to Enroll

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

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

Late Enrollees are not eligible to enroll except during the next Group Enrollment Period, or during a Special Enrollment Period.

Enrollment

All individuals meeting the eligibility requirements of this section may enroll with the Plan for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

Any new employee may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment.

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

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

Special Enrollment

Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee waived Coverage under the Plan at the time Coverage was most recently made available because the Eligible Employee or Dependent had group health plan or health insurance coverage (as defined by the Federal HIPAA Law) at the time Coverage under the Plan was offered and the Eligible Employee's or Dependent's other coverage:

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

Eligibility & Termination

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

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

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

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

Non-Participating Eligible Employee. An Eligible Employee who is eligible but has not yet enrolled may enroll, within thirty-one (31) days from the date of marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

Non-Participating Spouse. Your Spouse may enroll within thirty-one (31) days of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).

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.

New Dependents of non-enrolled Eligible Employee. A child who becomes a Dependent of a non-enrolled Eligible Employee as a result of marriage, birth, adoption or placement for adoption may enroll within thirty-one (31) days of that event, but only if the non-enrolled Eligible Employee is eligible for enrollment and enrolls at the same time.

Notwithstanding the above, a common law Spouse qualifies as a Spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.

Effective Date of Coverage. Coverage shall become effective the day of the qualifying event or the last day of coverage, whichever is later.

Notification of Change in Status. A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Employee Enrollment/Change Form to the Plan. Events

Eligibility & Termination

qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or Coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

Effective Date

During Group Enrollment Period: An Eligible Employee or Retiree, and their Eligible Dependent(s), who enroll during a Group Enrollment Period shall be Covered under this Agreement as of the date stated in the Group Master Contract.

Newly Hired Employees: A newly hired Eligible Employee, and their Eligible Dependent(s), shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage, according to the terms of the Group Master Contract, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Newly Eligible Employees: An Eligible Employee, and their eligible Dependent(s), who become eligible for Coverage under this Agreement during the contract year, shall be Covered as of the first (1st) day of the month following the date that he or she first becomes eligible so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Special Enrollees: Special enrollees shall be Covered under this Agreement as provided day of the qualifying event or the last day of coverage, whichever is later.

Qualified Medical Child Support Order ("QMCSO"): Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order ("QMCSO") shall be Covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Employer Group of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Employer Group, the parties may change the required Premium contribution of Subscribers.

Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in this Health Plan if either of the following two conditions are satisfied.

Termination of Medicaid or CHIP Coverage. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

Eligibility & Termination

Eligibility for Employment Assistance Under Medicaid or SCHIP. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

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

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

Termination of Coverage

Your Coverage shall terminate, upon the Plan's provision of a thirty-one (31) day notice, if any one of the following events occurs:

You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, upon termination of the Subscriber from Employment; the Member entering active military service; divorce or legal separation from the Subscriber; or when a Dependent child reaches the Limiting Age.

You are retired or pensioned, unless the Employer has included Retirees or those pensioned as eligible as referenced in the Group Master Contract.

You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the thirty-one (31) days notice period (and any grace period, if applicable), 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 thirty-one (31) days notice period (and any grace period, if applicable).

Termination of Coverage without Notice. Your Coverage shall immediately terminate if any one of the following events occurs:

- You participate in fraudulent or criminal behavior, including but not limited to:
 - √ Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
 - √ Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.
- Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application. The validity of the policy shall not be contested, except for non-payment of premiums, after the Plan has been in force for two years from the date of issue, and no initial statement made by a Member regarding insurability shall be

Eligibility & Termination

used as a reason for disenrollment after the Plan has been in force for two years from the date of issue.

- Termination or non-renewal of the Group Master Contract, by the Employer Group.
- The Plan receives written notice from the Employer Group instructing the Plan to terminate Your Coverage.

Effect of Termination.

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

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

If the Member receives 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.

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

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the COC, 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 COC shall be without prejudice to any continuous loss which commenced while the COC was in force, but the extension of benefits beyond the period the COC was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the COC.

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.

Covered Services

Covered Services

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this COC, and (4) incurred while the Insured is eligible for Coverage under the Plan. It is the Insured's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Schedule of Covered Services**, provides the services and supplies Covered under this COC. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in this COC. 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 in the schedule below are subject to all applicable Exclusions and Limitations of this COC.

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Allergy	Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	Exclusions: See Exclusion Section relating to allergy services.
Ambulance (air and ground)	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.	Exclusions: See Exclusion Section regarding ambulance services.
Blood and Blood Products Processing	Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this COC.	Exclusions: See Exclusion Section regarding blood and blood products.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for (1) augmentation and reduction of the affected breast, (2) augmentation or reduction on the opposite breast to restore symmetry, (3) prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.	Exclusions: See Exclusion Section regarding Reduction or Augmentation Mammoplasty.
Cardiac Rehabilitation Services	Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	improvement of Your condition.	
Chemotherapy	Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.	Limitations: Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Insured pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.	
Contraceptive Devices	Coverage is provided for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.	
Dental Services	<p>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:</p> <p>(1) 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</p> <p>(2) The patient is:</p> <p>(A) 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;</p> <p>(B) A person with a diagnosed serious mental or physical condition; or</p> <p>(C) A person with a significant behavioral problem as determined by the Insured's physician.</p> <p>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.</p>	<p>Limited benefit.</p> <p>Exclusions: See Exclusions Section regarding dental services.</p>
Dermatological Services	Coverage is provided for the necessary removal of a skin lesion that interferes with normal body	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	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 Supplies	Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes.	Limitations: Disposable insulin syringes, 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 this COC.
Durable Medical Equipment (“DME”)	<p>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 member.</p> <p>The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME.</p>	<p>Upgrades to equipment are the responsibility of the Insured.</p> <p>Exclusions: See Exclusions Section regarding DME Coverage.</p>
Emergency Services	Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and Pre-Certification is not required.	You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.
Eye Glasses and Corrective Lenses	Not a Covered Service, except for the first pair of eyeglasses or corrective lenses following cataract surgery	Exclusions: See Exclusions Section regarding eyeglasses and contact lenses.
Genetic Counseling and Studies	Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	abnormalities and the testing will alter the outcome of treatment.	
Gynecological Examinations	Coverage is provided for routine well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.	
Hearing Screenings	Coverage is provided for a hearing screening to determine hearing loss.	
Home Health Care Services	<p>Coverage is provided when <u>all</u> of the following requirements are met:</p> <ul style="list-style-type: none"> (1) the service is ordered by a Physician; (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist; (3) part-time intermittent services are required; (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and (5) the agency rendering services is licensed by the State of location. 	Exclusions: See Exclusions Section regarding Home Services.
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Insured 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, and guidance and assistance during the Illness for the purpose of preparing the Insured and the Insured's family for a terminal Illness.	
Infertility Treatment	<p>Coverage is provided for You or Your Spouse the patient's oocytes are fertilized with the sperm of the patient's spouse, and</p> <ul style="list-style-type: none"> ▪ a history of unexplained infertility of at least two (2) years' duration; or ▪ the infertility is associated with one or more of the following medical conditions: <ul style="list-style-type: none"> ○ Endometriosis; ○ Exposure in utero to Diethylstilbestrol, commonly known as DES; ○ Blockage of or removal of one or both fallopian tubes (lateral or bilateral 	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>salpingectomy) not a result of voluntary sterilization; or</p> <ul style="list-style-type: none"> ○ Abnormal male factors contributing to the infertility, and ▪ when performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization; ▪ unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy. <p>Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.</p>	
Inpatient Hospital Care	<p>Coverage includes semi-private accommodations and associated professional and ancillary services.</p> <p>Certain services rendered during the Insured's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.</p>	<p><u>Exclusions:</u> See Exclusions Section regarding Private inpatient room.</p>
Laboratory and Pathology Services	<p>Coverage is provided as listed in the Schedule of Benefits.</p>	
Maternity Services	<p>Maternity-related Covered Services are treated as any other Illness. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. Inpatient Hospital services may be subject to Insured responsibility as defined in the Schedule of Benefits.</p>	<p><u>Exclusions:</u> See Exclusions Section regarding maternity services.</p>

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Newborn Care	<p>The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria (“PKU”) and such other common metabolic or genetic diseases.</p> <p>Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.</p>	
Nutritional Counseling	Coverage is provided when provided by a registered dietician.	
Oral Surgery and Diseases of the Mouth	<p>Coverage includes only oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.</p> <p>Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.</p>	Exclusions: See Exclusions Section regarding oral surgery and dental services.
Orthotic Devices	Coverage is provided for the initial 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 <u>only</u> if the Insured has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.	Exclusions: See the Exclusions Section regarding Orthotic Appliances.
Osteoporosis	Coverage is provided for services related to diagnosis, including central bone density tests; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.	
Outpatient Diagnostic Services	Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any other outpatient diagnostic service. Also covered	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.	
Outpatient Surgery	Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Provider at a Hospital or Alternate Facility.	
Outpatient Therapy Services	Coverage is provided for short-term outpatient therapy services that are expected to result in significant functional improvement of the Insured's condition, limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.	Exclusions: See Exclusions Section.
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.	
Physician Services	Coverage is provided for Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.	
Preventive Services	<p>The preventive health services referenced below shall be covered, in a manner consistent with Section 2713 of Federal H.R. 3590.</p> <p>A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;</p> <p>B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention ("ACIP - CDC");</p> <p>C. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and</p> <p>D. Additional preventive care and screenings for women (including breast cancer screening and</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>mammography screenings) not described in paragraph (A).</p> <p>A list of the preventive services covered under this paragraph 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 Service number on Your identification card.</p>	
Prosthetic Devices	<p>Coverage is provided for the initial 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, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.</p> <p>Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Insured; (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.</p> <p>Prosthetics will be replaced for documented growth in a child requiring replacement.</p> <p>Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.</p>	<p>Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal prosthetic devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit.</p> <p><u>Exclusions:</u> See Exclusions Section regarding Prosthetic Devices.</p>
Pulmonary Rehabilitation Services	<p>Coverage is provided, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.</p>	
Radiation Therapy	<p>Coverage is provided for standard radiation therapy.</p>	
Radiology	<p>Coverage is provided as determined by the Plan.</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.	<p>Limitations: Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for dependent children [through age eighteen (18)].</p> <p>Exclusions: See Exclusions Section regarding Cosmetic Services and Surgery.</p>
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Insured's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.	<p>Exclusions: See Exclusions Section regarding rehabilitation services and supplies.</p>
Sleep Studies	Covered Services.	<p>Exclusions: See Exclusion Section regarding sleep studies.</p>
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility. Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	<p>Limitations: Coverage in a Skilled Nursing Facility may be subject to a Benefit Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during the Insured's Confinement are subject to separate benefit restrictions and/or Insured responsibilities as described elsewhere in this COC or in the Schedule of Benefits.</p>
Spinal Manipulation Services	<p>The following services are Covered when they are delivered by a duly licensed Provider acting within the scope of his or her license:</p> <ul style="list-style-type: none"> • Initial Examinations <p>Coverage includes the initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Insured's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems may be done if appropriate clinical indications</p>	

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>are present and documented. Vital signs should be included in examinations when appropriate.</p> <ul style="list-style-type: none"> • Subsequent Office Visits <p>This may include an adjustment, a brief examination and other Medically Necessary services.</p> <ul style="list-style-type: none"> • Re-examination <p>This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.</p>	
Sterilization (voluntary)	Covered Service.	<u>Exclusions:</u> See Exclusions Section regarding reversal of sterilization.
Therapeutic Injections and IV Infusions.	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.	<p><u>Limitations:</u> Certain Self-Injectable medications may be Covered by a pharmacy Rider and therefore excluded from the medical benefit.</p> <p><u>Exclusions:</u> See Exclusions Section regarding Prescription medications.</p>
Transplants	<p>Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is an Insured.</p> <p>Donor screening tests are Covered and when performed at a Coventry Transplant Network participating facility.</p> <p>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-Insured when the recipient is an Insured will be Covered for the duration of the COC.</p> <p>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.</p> <p>The cost of any care, including complications,</p>	<u>Exclusions:</u> See Exclusions Section regarding transplant services.

Covered Services

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED	LIMITATIONS
	<p>arising from an organ donation by the Insured when the recipient is not an Insured is excluded.</p> <p>If the Insured resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.</p>	
Urgent Care Services	<p>Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician <u>will not</u> result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.</p>	
Vision Services	<p>Coverage is provided for eye examination to include, if Medically Necessary, 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.</p>	<p><u>Exclusions:</u> See exclusions section regarding Vision Services.</p>

Exclusions and Limitations

General Exclusions

Unless otherwise stated in this COC, the following items are excluded from Coverage:

- 1) 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 COC;
- 2) Any service or supply that is not Medically Necessary;
- 3) Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service;
- 4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Insured has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the COC;
- 5) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
- 6) Court-ordered services or services that are a condition of probation or parole;
- 7) Those services otherwise Covered under the COC, but rendered after the date Coverage under the COC terminates, including services for medical conditions arising prior to the date individual Coverage under the COC terminates; and
- 8) 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 the Insured, or rendered by a person who is a member of the Insured's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

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

- 1) **Acupuncture** - Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;
- 2) **Allergy Services** - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
- 3) **Alternative Therapies** - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;
- 4) **Ambulance Service** - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Insured;
- 5) **Augmentative Communication Devices** – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Insureds;
- 6) **Autopsy** - Those services and associated expenses related to the performance of autopsies, and also post-mortem genetic studies;
- 7) **Behavior modification;**
- 8) **Biofeedback;**

Exclusions and Limitations

- 9) **Blood and Blood Products - The cost of whole blood and blood products replacement to a blood bank;**
- 10) **Blood Storage** - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;
- 11) **Braces and supports needed for athletic participation or employment;**
- 12) **Charges resulting from Your failure to appropriately cancel a scheduled appointment;**
- 13) **Cochlear Implants** and related services;
- 14) **Cosmetic Services and Surgery** - Those services, associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes;
- 15) **Counseling Services** and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;
- 16) **Custodial Care**, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists the Insured 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 regardless of who orders the services;
- 17) **Dental Services** - Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this COC. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

Also excluded from coverage are dental services when such services are directly related to an accidental injury. This includes but is not limited to treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury.

Removal of teeth, including any prophylactic extractions, as a complication of radionecrosis is not a Covered Service
- 18) **Dental Surgery and Implants** - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded.;
- 19) Medical services and expenses incurred for learning disabilities, **developmental delays**, mental retardation, and autistic disorders.
- 20) **Durable Medical Equipment ("DME")** - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home blood pressure monitoring devices; home oximetry units; home traction units; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or

Exclusions and Limitations

- negligence of items owned by the Insured; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;
- 21) **Educational Services** Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;
 - 22) **Equipment** or services for use in altering air quality or temperature;
 - 23) Educational testing or psychological testing, unless part of a treatment program for Covered Services;
 - 24) **Elective or Voluntary Enhancement** - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;
 - 25) **Eligible Expenses** - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;
 - 26) **Enteral Feeding Food Supplement** - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease for food or formula;
 - 27) **Examinations** - Unless otherwise Covered under the Covered Services Section, those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;
 - 28) **Exercise equipment**, hot tubs and pools;
 - 29) **Eye Glasses and Contact Lenses** - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;
 - 30) **Food or food supplements** , regardless of whether it is the sole source of nutrition except as provided under for PKU, Amino or Organic Acid Inherited Disease;
 - 31) **Foot Care** – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Insured;
 - 32) **Foreign Travel** - care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services;
 - 33) **Growth Hormone** – Growth hormone therapy for any condition, except in children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

Exclusions and Limitations

- 34) **Hair analysis, wigs and hair transplants** - Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;
- 35) **Home services to help meet personal, family, or domestic needs;**
- 36) **Health and Athletic Club Membership** - Any costs of enrollment in a health, athletic or similar club;
- 37) **Hearing Services and Supplies** - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests, unless Covered by an attached Hearing Aid Rider;
- 38) **Household Equipment and Fixtures** - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;
- 39) **Hypnotherapy and Hypnosis;**
- 40) **Immunizations** unless specifically covered under the COC, including but not limited to immunizations required for travel, school, work-related, Anthrax vaccine and Lyme Disease vaccine. Also excluded are examinations and testing in connection with insurance, obtaining employment, specifically for the purpose of entering school, participating in extracurricular school activities, adoption, immigration and naturalization, or examinations or treatment ordered by a court or an employer; premarital blood testing;
- 41) **Infertility/Reproductive Services** - All diagnostic studies, non-diagnostic services, and certain surgical procedures that are related to diagnosing and/or treating Infertility, except as described in Covered Services; and reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis (for example, determining sex) , other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered under the terms of the COC;
- 42) **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;
- 43) **Maintenance Therapy** – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;
- 44) **Male Gynecomastia** – Those services and associated expenses for treatment of male gynecomastia.
- 45) **Massage Therapy** – Those services and associated expenses related to massage therapy;
- 46) **Medical complications** arising directly or indirectly from a non-Covered Service;

Exclusions and Limitations

- 47) **Mental Health Services** - the diagnosis and treatment of all biologically based Mental Illnesses and psychiatric conditions, unless Covered by an attached Mental Health Substance Abuse Rider;
- 48) **Military Health Services** - Those services for treatment of military service-related disabilities when the Insured is legally entitled to other Coverage and for which facilities are reasonably available to the Insured; or those services for any Insured who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- 49) **Miscellaneous Service Charges** - Telephone consultations, document processing or copying fees, mailing costs, charges for completion of forms, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), any late payment charge, interest charges or other non-medical charges;
- 50) **Non-Prescription Drugs and Medications** - Over-the-counter (“OTC”) drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider;
- 51) **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 under for PKU, Amino or Organic Acid Inherited Disease for food or formula;
- 52) **Newborn** home delivery and also the cost of child birth classes;
- 53) **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, jejunal 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;
- 54) **Occupational Injury** - Those services and associated expenses related to the treatment of an occupational Injury or Illness for which the Insured is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation benefit, medical benefits that would have been compensable except for the settlement will not be Covered Services under this COC;
- 55) **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;
- 56) **Orthodontia** and related services;
- 57) **Orthotic Appliances, Repairs or Replacement** - The replacement costs for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Insured; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated; also excluded are cranial (head) remodeling band for the treatment of postitional non-synostotic plagiocephaly; and other protective head gear;

Exclusions and Limitations

- 56) **Over-the-counter supplies** such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also 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, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider;
- 59) **Personal comfort and convenience** items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;
- 60) **Prescription Drugs and Medications** - Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this COC or as specifically provided in an optional pharmacy Rider.
- 61) **Private Duty Nursing** - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;
- 62) **Prosthetic Devices Repairs or Replacement** - The 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 owned by the Insured;
- 62) **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;
- 64) **Reduction or Augmentation Mammoplasty** - Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer;
- 65) **Reversal of Sterilization Services** - Those services and associated expenses related to reversal of voluntary sterilization;
- 66) **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;
- 67) **Sexual Dysfunction** - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;
- 68) **Sleep Studies – Sleep studies provided within the home;**
- 69) **Smoking Cessation** - Those services and supplies for smoking cessation programs and treatment of nicotine addiction;
- 70) **Speech therapy** or voice training when prescribed for stuttering or hoarseness;
- 71) **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 and orthotics;
- 72) **Substance Abuse** diagnosis and treatment, unless Covered by an attached Mental Illness Substance Abuse Rider;
- 73) **Surrogate motherhood** services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of the Insured acting as a surrogate mother;

Exclusions and Limitations

- 75) **Transplant Organ Removal** - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not Covered under the COC unless the recipient is the Insured and the donor's medical Coverage excludes reimbursement for organ harvesting;
- 76) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when the Insured is donating organ or tissue to a person not Covered under the COC;
- 77) **Transplant Services** and associated expenses involving temporary or permanent mechanical or animal organs;
- 78) **Travel Expenses** - Travel or transportation expenses, even though prescribed by a Provider, except as specified in the Covered Services Section;
- 79) **Treatment for disorders** relating to learning, motor skills and communication;
- 80) **Vision Aids, Associated Services** - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;
- 81) **Vocational therapy**;
- 82) Health services resulting from **war or an act of war** when the Insured is outside of the continental United States; and
- 83) **Work hardening programs**.

Coordination of Benefits

This section describes how Benefits under this COC will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

Definitions

A **Plan**, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

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

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

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

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

Coordination of Benefits

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

“Joint Custody” If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined below.

Order of Benefit Determination Rules

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

- The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- 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.
- 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 Insured other than as a Dependent, for example as an employee, Insured, Subscriber or retiree is Primary and the Plan that covers the Insured as a Dependent is Secondary. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Insured as a Dependent; and Primary to the Plan covering the Insured 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 Insured as an employee, Insured, 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:
 - 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
 - If both parents have the same birthday, the Plan that Covered either of the parents longer is Primary.
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care Coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

Coordination of Benefits

- 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 Insured as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Insured 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.
- √ Continuation coverage. If a Insured 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 Insured as an employee, Insured, Subscriber or retiree (or as that Insured'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 Insured as an employee, Insured, 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. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

Effect On The Benefits of the Plan

- The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

- a) If an employee is eligible for Medicare and works for an Employer Group with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, then Medicare will be the primary payer. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis.
- b) If an employee works for an Employer Group with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding the Calendar Year, the Plan will be primary. However, an employee may decline Coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare -Covered services.

Coordination of Benefits

You will continue to be Covered by the Plan as primary unless You (a) notify the Plan, in writing, that You do not want benefits under the Plan or (b) otherwise cease to be eligible for benefits under the Plan, or (c) if we determine through some other means that we are not the primary carrier.

Disability

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

End Stage Renal Disease (“ESRD”)

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

Coordination of Benefits for Retirees

- a) If You are retired and You or one of Your Dependents is Covered by Medicare Part A and/or Part B (or would have been Covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:
 - (i) Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
 - (ii) Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been Covered by Medicare; or
 - (iii) Amounts paid under all other plans in which You participate.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

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

Facility of Payment

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

Right of Recovery

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

- The persons it has paid; or
- For whom it has paid; or
- Insurance companies; or
- Other organizations.

Right of Reimbursement

In consideration of the coverage provided by this COC, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as “Third Parties”. You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - √ Providing any relevant information requested by Us,
 - √ Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
 - √ Responding to requests for information about any accident or injuries,
 - √ Making court appearances, and
 - √ Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;

Coordination of Benefits

- That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or a non-economic damage settlement or judgment;
- That Benefits paid by Us may also be considered to be Benefits advanced;
- That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
- That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
- That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
- That We shall not be obligated in any way to pursue this right independently or on Your behalf.

Complaints & Appeals

The Insured may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Insured or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this COC.

Complaints

A complaint is an 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.

The address and telephone numbers for Complaints are:

Coventry Health & Life Insurance Company
[P.O. Box 7109]
[London, KY 40742]
Telephone: [(800) 969-3343]

Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Insured and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. The Appeals must be made within 180 days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health & Life Insurance Company
Attn: Appeals Department
[8320 Ward Parkway]
[Kansas City, MO 64114]

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

One level of internal Appeal is provided if You, or your Authorized Representative, disagree with an Adverse Benefit Determination. The Insured or Authorized Representative may file an Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that field of medicine.

- Appeals are concluded as follows:

- √ Urgent Care Appeals –Urgent Care Appeals will be completed within 72 hours after receipt of the Appeal request. We will notify the Insured and/or Authorized Representatives verbally and provide a follow-up written notice within 3 calendar days after the verbal notification.

Complaints & Appeals

- √ Pre-service Appeals – Requests for Pre-service Appeals will be acknowledged by letter upon receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 30 calendar days of receipt of the Appeal request;
- √ Post-service Appeals – Requests for Post-service Appeals will be acknowledged by letter upon receipt of the Appeal request. We will complete our investigation and notify the Insured and/or Authorized Representatives within 60 calendar days from the date of the request for a Appeal.

Our written notification to the Insured or Authorized Representative will provide the reason for the decision. Our notice will give the Insured or Authorized Representative instructions on any additional Appeal Rights available. The written notice will also include information on applicable review processes available under state law.

External Appeals

Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. Only appeals that are related to an Adverse Determination that involve treatment, services, equipment, supplies, or drugs that would require the Plan to expend five hundred dollars (\$500) or more are afforded an external independent review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service. The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. The independent review organization shall make a determination and verbally notify You, Your authorized representative, Your attending Physician and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

Contact Information

You may contact your respective the 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.

Continuation of Coverage

Consolidated Omnibus Budget Reconciliation Act (“COBRA”)

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

Insureds who selected continuation Coverage under a prior plan which was replaced by Coverage under this COC shall be Covered until termination as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier.

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

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

Continuation Coverage Under Arkansas State Law

Covered Person whose coverage under the Group Policy are entitled to continue their Hospital, surgical or major medical coverage, including coverage for their eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- You have been Covered for at least a three (3) month period before termination;
- You were not terminated for cause as permitted by the Group Master Contract;
- The discontinued group Coverage was not replaced with similar group Coverage within thirty-one (31) days;
- You are not and do not become eligible for Medicare Coverage; and
- You are not eligible for any other Hospital, Physician and/or major medical Coverage for individuals in a group.

Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period

The Covered Person must do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Employer Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the Group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify You, in writing, of its duties under this subdivision not later

Continuation of Coverage

than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

- The date four (4) months after the date Your Coverage under this COC would have terminated because of termination of employment;
- If You fail to make timely payment of a required Premium contribution, the end of the period for which contributions were made;
- The date this COC is terminated or, in the case of a Subscriber, the date the Employer Group terminates participation under the Agreement. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Agreement, then You shall have the right to become covered under that other policy for the balance of the period that:
 - You would have remained covered under this COC in accordance with the conditions of this section;
 - The minimum level of Benefits to be provided by the other Agreement shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and
 - The prior Group Agreement shall continue to provide Benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

- Reasons for termination:
- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Agreement ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for Fraud or Misrepresentation;
- The Group Agreement terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Agreement within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this COC. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this policy.

Continuation of Coverage

The converted policy shall cover You and Your dependents who were covered by this COC on the date of termination of insurance. At the option of the Plan, a separate converted policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar benefits by another policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar benefits are provided for or available to such person, by reasons of state or Federal law; and
- The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

General Provisions

Applicability

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

Governing Law

This COC is delivered and governed by the laws of the State of Arkansas for Arkansas residents.

Legal Actions

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

You must exhaust the Plan's Complaint and Appeal Procedures prior to pursuing legal action, (in a court or other government tribunal) as this may be the most expeditious and cost-effective method of resolving Your concerns.

Time Limit On Certain Defenses

After two years from the date of issue of this Agreement no misstatements, except fraudulent misstatement, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this Agreement 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 Agreement.

Nontransferable

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

Relationship Among Parties Affected by this Agreement

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

Neither the Employer Group nor You are agents or representatives of the Plan, and shall not be liable for any acts or omissions of the Plan for the performance of services under this Agreement.

Contractual Relationships

The Plan agrees with the Employer Group to provide Coverage for services to You, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Employer Group's Group Master Contract. This COC is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Group Master Contract in place between the Plan and the Employer Group, and the Employer Group's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Employer Group is given thirty-one (31) days advance written notice.

General Provisions

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

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

COC's will be provided to the Employer Group by the Plan for distribution to all Insureds.

The Plan is Not Employer

The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Employer Group's benefit plan. The Plan shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Employer Group's benefit plan.

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 the Insured. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

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

Entire Agreement

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this Agreement. Amendments to the COC are effective upon thirty-one (31) days written notice to the Insured. No change will be made to the Agreement unless made by an Amendment or a Rider that is issued by the Plan. No agent or representative has authority to change the Agreement or to waive any of its provisions.

This Agreement, including all matters incorporated, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Agreement, including the application agreement, and all endorsements, exhibits, addenda, or amendments, if any, supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

Valid Amendment

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

Waiver

General Provisions

The failure of the Plan or You to enforce any provision of this COC 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 COC shall not be deemed or construed to be a waiver of such default.

Records

The Insured 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 Agreement in the event the Plan is unable to obtain this information directly from the Provider or previous insurer.

By accepting Coverage under the COC, the Insured, who has signed the application, authorizes and directs any person or institution that has provided services to the Insured, to furnish the Plan or any of the Plan's designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Insured. 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 the COC or for appropriate medical review or quality assessment.

Examination of the Insured

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 the Insured at the Plan's expense.

ERISA

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

Clerical Error

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

Notice

Written notice given by the Plan to an Employer Group, or an Authorized Representative of the Employer Group, is deemed notice to all affected Subscribers and their enrolled Dependents in the administration of Coverage under the COC, including termination of Coverage. The Employer Group is responsible for giving notice to Insureds.

Workers' Compensation

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

Conformity with Statutes

Any provision of the Agreement 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

General Provisions

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

Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by or on behalf of a Insured, 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 Agreement.

Discretionary Authority

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

Value Added Services

From time to time the Plan may offer to provide Insureds access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Plan is not liable to the Insureds 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.

Important Numbers & Addresses

<p>Customer Service / Claims</p> <p>[Coventry Health & Life Insurance Company Customer Service PO Box 7109 London, KY 40742</p> <p>(800) 969-3343</p> <p>(866) 285-1864 TDD</p> <p>http://www.chckansas.com/]</p>	<p>Pre-Certification</p> <p>[Coventry Health & Life Insurance Company 8320 Ward Parkway Kansas City, MO 64114</p> <p>(877) 837-8914]</p>
<p>Appeals and Grievance</p> <p>[Coventry Health & Life Insurance Company Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114]</p>	<p>Arkansas Department of Insurance</p> <p>[1200 West Third St Little Rock, AR 72201</p> <p>(800) 282-9134 Insurance.Consumers@arkansas.gov]</p>
<p>[MH Net Behavioral Health]</p> <p>[PO Box 209010 Austin, TX 78720 (866) 607-5970</p> <p>www.chckansas.com]</p>	



May 26, 2011

SERFF DOCUMENT

Arkansas Department of Insurance
Health & Life Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: Employer Group Product, et al
Coventry Health & Life Insurance (NAIC# 1137-81973)

Dear Sir or Madam:

Enclosed, please find form filings for Coventry Health & Life Insurance Company, including Certificate of Coverage, et al, Group Master Contract, and applicable Applications/Enrollment forms. Our intent is to offer this product within the state of Arkansas effective September 1, 2011. These forms are PPACA compliant.

Statement of Variability

All forms contain bracketed variables around Coventry Health Care of Kansas, Inc. ("CHC-KS"), a subsidiary of Coventry Health Care, Inc. CHC-KS is intended to be the administrator of this product.

All forms contain bracketed variables around the address, phone, and website information. This is intended to be modifiable as necessary, should this product be administered by another Coventry Health Care company maintaining Arkansas licensure.

Form CHL-AR-COC-011-05.11 contains policy language with in brackets. This is not variable language and will either remain or be deleted in its entirety.

The Riders are offers of coverage. Each offer is depicted on the application and may be elected. The rates for such will be defined in the Sales & Marketing materials supplied with the application at the time of sale. In contrast the Endorsements or Mandated Benefit Offerings and will be included with the Certificate of Coverage at distribution, but have been separated by Endorsement due to our internal administration processes.

Form CHL-AR-RID-013-05.11 (Pharmacy Rider) and CHL-AR-SOB-003-10.10 (Schedule of Benefits) have a benefit grid for cost share at a Participating Provider or Non-Participating Provider. Coventry certifies that the out of network differential will be no more than 25% greater than the in-network cost share. The bracketed numerical variables are ranges for copayment, deductibles, and coinsurance amounts. The bracketed text is not variable. It will either be left as written or deleted.

Form CHL-AR-GMC-020-05.11 (Group Master Contract) is the Employer Group Policy. The time limits for grace period and premium payment have been bracketed as variable. Additionally, the attachments are variable and will include the above filed and approved forms depending on the plan purchased by the Employer Group.

Certification of Arkansas Mandated Coverage

Coventry recognizes the mandates Children's Preventive Health Care, Colorectal Cancer Screening, and Prostate Cancer Screening. These are now part of PPACA regulation and as such defined accordingly.

Coventry recognizes the mandate for In-Vitro Fertilization. AR 23-85-137, and Rule 1 indicate this benefit to treated as similar to Maternity coverage. Under PPACA lifetime limits may no longer apply; however, Infertility treatment is not considered an "essential benefit" and as such a Benefit Year limit was added as a bracketed variable.

Mandated offerings for Hospice, Mammogram, out-patient service, and psychological examiners have been adapted to standard coverage and subject to the coverage, exclusions, and scope of the Certificate like any other service.

Coverage acknowledges the mandate of coverage for Breast Reconstruction/Mastectomy, Dental Anesthesia, Diabetic Supplies/Education, Prescription and Contraceptive drugs, PKU, Loss or Impairment of Speech or Hearing, Newborn coverage, Off-Label Drug Use, and Orthotic and Prosthetic Devices and certifies that each are, if not specifically defined in the Certificate, are administered in accordance with the mandate.

Please contact me with any questions regarding these documents. You can reach me at 866-795-3995, extension 4539, facsimile at 866-701-2517, or via email at jesimms@cvty.com. I look forward to your response.

Respectfully submitted,

Jennifer Simms

Jennifer Simms
Regulatory Compliance Analyst