COMMON GROUND
HEALTHCARE COOPERATIVE

INDIVIDUAL CERTIFICATE OF COVERAGE, AMENDMENTS AND NOTICES

If you receive coverage through your employer, click here to view your Certificate of Coverage

Certificate ID Number: CGHC.2000

Effective Date: January 1, 2016

Offered and Underwritten by

Common Ground Healthcare Cooperative
YOUR RIGHT TO RETURN POLICY

Please read your Policy immediately. If you are not satisfied with it for any reason, you can return it within 10 days from receipt of this Policy. Upon return, this Policy becomes invalid. We will refund any premium payments you have made.

GUARANTEED RENEWABILITY

This Policy is guaranteed renewable unless one of the exceptions in the When Coverage Ends section becomes applicable.

To receive the highest level of covered Benefits at the lowest out-of-pocket cost, covered services must be provided by an In-network provider. Participating providers have agreed to accept discounted payment for Covered Health Services with no additional billing to the Covered Person other than Copayment, Coinsurance and Deductible amounts.

Coverage of eligible Benefits provided by Non-Network Providers is limited to the amount We determine in accordance with the Definitions in Section 7 of this Certificate. We calculate the cost of Eligible Expenses based on available data resources of competitive fees in specific geographic areas. Eligible Expenses cannot be greater than the fees that the Non-Network Provider would charge any other health plan in the same or similar situation for the same services. You may be responsible for paying any difference between the amount the Non-Network Provider charges you and the amount We will pay for these Eligible Expenses.

Your health Plan limits Benefits for eligible services to the Maximum Allowed Amount as defined in the “Definition” section of this Certificate. The Maximum Allowed Amount may be less that the amount billed by your provider. You may obtain further information about the status of professional providers and information on out-of-pocket expenses by calling the Member Services Department number on your identification (ID) card or by going to www.COMMONGROUNDHEALTHCARE.ORG.
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COMMON GROUND HEALTHCARE COOPERATIVE
CERTIFICATE OF COVERAGE

CERTIFICATE OF COVERAGE IS PART OF POLICY

This Certificate is part of the Policy that is a legal document between Common Ground Healthcare Cooperative (CGHC) and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on your application and payment of the required Policy Charges.

In addition to this Certificate the Policy includes:

- The Schedule of Benefits
- Amendments
- Notices

You can review the Policy at Common Ground Healthcare Cooperative during regular business hours.

CHANGES TO THE DOCUMENT

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. When that happens We will send new Certificate, Rider or Amendment pages. No one can make any changes to the Policy unless those changes are in writing.

OTHER INFORMATION YOU SHOULD HAVE

We have the right to change, interpret, modify, withdraw, add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its Effective Date, this Certificate replaces and overrules any Certificate that We may have previously issued to you. This Certificate will in turn be overruled by any Certificate We issue to You in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of your location. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Wisconsin.
INTRODUCTION TO YOUR CERTIFICATE

We are pleased to provide you with this Certificate. This Certificate describes your Benefits, as well as your rights and responsibilities.

HOW TO USE THIS DOCUMENT

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully.

We encourage you to review the Benefits and the limitations of this Certificate by reading the Schedule of Benefits along with Section 1: Covered Health Services and Section 2: Exclusions and Limitations. You should also carefully read Section 6: General Legal Provisions to better understand how this Certificate and your Benefits work. You should call Us if you have questions about the limits of the coverage available to you.

Many of the sections of this Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We would encourage you to keep your Certificate and Schedule of Benefits and any attachments in a safe place for your future reference.

If there is a conflict between this Certificate and any summaries provided to you, this Certificate will control with respect to the Benefits We are obligated to provide to you.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

INFORMATION ABOUT DEFINITIONS

Because this Certificate is part of a legal document, We want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 7: Health Services Definitions. You can refer to Section 7: Health Services Definitions as you read this document to have a clearer understanding of your Certificate.

When We use the words "We," "Us," and "Our" in this document, We are referring to Common Ground Healthcare Cooperative. When We use the words "you" and "your," We are referring to people who are Covered Persons, as that term is defined in Section 7: Health Services Definitions.

DON’T HESITATE TO CONTACT US

Throughout the document you will find statements that encourage you to contact Us for further information.

Whenever you have a question or concern regarding your Benefits, please call Us using the telephone number for the Member Services Department listed on your ID card. It will be Our pleasure to assist you.
YOUR RESPONSIBILITIES

PAYING REQUIRED PREMIUMS

You must make Premium payments to Us by the due date in order for you to remain enrolled to receive Benefits. Your Premium is due on the 25th of the month for the following month. You have a grace period for paying Premiums. If you receive an advance premium tax credit (APTC) and you fail to pay your Premium when due you are given a 90 day grace period which begins on the 1st day of the coverage month for which Premium was not received. If full payment of your Premium is not received by the end of the grace period, then We may terminate your coverage as of the last day of the first month of the 90 day grace period. If you do not receive an advance premium tax credit, and you fail to pay Premiums within 31 days after the due date, then We may terminate your coverage as of the last day of the last month for which We received Premiums.

Except for annual changes to your premium based on your age, we generally won’t change your Premium unless we change the Premium of everyone to whom we issued this Policy in your service area. However, if you become covered under this Policy as a non-tobacco user and we determine that you are a tobacco user, we will modify Premium rates applicable to you to reflect this status. If we increase your Premium by more than 25%, we will provide you with 60 days’ prior written notice.

BE AWARE THIS POLICY DOES NOT PAY FOR ALL HEALTH SERVICES

Your right to Benefits is limited to Covered Health Services. The extent of this Policy’s payments for these Covered Health Services and any obligation that you may have to pay for a portion of the cost of these Covered Health Services is set forth in the Schedule of Benefits.

DECIDE WHAT SERVICES YOU SHOULD RECEIVE

Decisions on your care are between you and your Physicians. We do not make the decision about the kind of care you should or should not receive. If you choose to receive care that is not a Covered Health Service, you may have to pay the entire cost of that care.

CHOOSE YOUR PHYSICIAN

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals’ and facilities’ licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

PAY YOUR SHARE

You must pay an Annual Deductible, Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Network Provider. Deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. You may also be required to pay any amount that exceeds Eligible Expenses received from a Non-Network Provider.

PAY THE COST OF EXCLUDED SERVICES
You must pay the cost of all excluded services and items. Review Section 2: Exclusions and Limitations to become familiar with this Benefit Plan’s exclusions.

SHOW YOUR IDENTIFICATION CARD

You should show your identification card (ID) every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to receive Benefits.

OUR RESPONSIBILITIES

DETERMINE BENEFITS

We make administrative decisions regarding whether this Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Certificate, the Schedule of Benefits, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at Our discretion. In order to receive Benefits, you must cooperate with those service providers.

PAY FOR OUR PORTION OF THE COST OF COVERED HEALTH SERVICES

We pay Benefits for Covered Health Services as described in Section 1: Covered Health Services and in the Schedule of Benefits, unless the service is listed as a Benefit exclusion in Section 2: Exclusions and Limitations. This means We only pay Our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

PAY NETWORK PROVIDERS

It is the responsibility of Network Providers to file for payment from Us. When you receive Covered Health Services from Network Providers, you do not have to submit a claim to Us.

PAY FOR COVERED HEALTH SERVICES PROVIDED BY NON-NETWORK PROVIDERS

In most cases your Non-Network Providers will file your claims directly with Us. We will pay Covered Health Services based on a Maximum Allowed Amount. You are responsible for Deductibles, Copayments and/or Coinsurance plus any amount over the Maximum Allowed Amount.
REVIEW/DETERMINE BENEFITS IN ACCORDANCE WITH OUR REIMBURSEMENT POLICIES

We develop Our reimbursement Policy guidelines, in Our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that We accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), Our reimbursement policies are applied to provider billings. We share Our reimbursement policies with Network Providers. Network Providers may not bill you for the difference between their contract rate (as may be modified by Our reimbursement policies) and the billed charge. However, Non-Network Providers are not subject to this prohibition, and may bill you for any amounts We do not pay, including amounts that are denied because one of Our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain reimbursement information by calling the Member Services Department at the telephone number on your ID card.
YOUR COVERAGE

WHEN COVERAGE BEGINS

HOW TO ENROLL

Eligible Persons must complete an application. You may apply through the American Health Benefits Exchange also called the Health Insurance Marketplace, and hereinafter called “the Marketplace,” or you may obtain an application directly from Us. We will not provide Benefits for health services that you receive before Your Effective Date of coverage.

IF YOU ARE HOSPITALIZED WHEN YOUR COVERAGE BEGINS

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, We will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier’s obligations under state law or contract.

You should notify Us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network Providers.

IF YOU ARE ELIGIBLE FOR MEDICARE

Your Benefits under the Policy will be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Policy will also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) Plan but fail to follow the rules of that Plan. Please see Medicare Eligibility in Section 6: General Legal Provisions for more information about how Medicare may affect your Benefits.

WHO IS ELIGIBLE FOR COVERAGE

If you apply for coverage through the Marketplace, the Marketplace will determine whether you are eligible to enroll under the Policy and who qualifies as a Dependent. If you apply directly with Us, then We determine who is eligible to enroll under the Policy and who qualifies as a Dependent.

ELIGIBLE PERSON

Eligible Person usually refers to a Member who meets the eligibility rules. When an Eligible Person actually enrolls, We refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see Section 7: Health Services Definitions.

Eligible Persons must reside within the United States.

DEPENDENT
Dependent generally refers to the Subscriber’s spouse and children. When a Dependent actually enrolls, We refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 7: Health Services Definitions.

WHEN TO ENROLL AND WHEN COVERAGE BEGINS

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

INITIAL ENROLLMENT PERIOD

When you purchase coverage under the Policy from Us or through the Marketplace, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

If an Eligible Person enrolls during the Initial Enrollment Period, coverage is effective on the first day of the month following receipt of the application if it is received between the 1st and 15th day of any month. If an application is received between the 16th day and the last day of the month, coverage is effective the first day of the second following month. We must receive any required Premium before your coverage is effective.

OPEN ENROLLMENT PERIOD

After the Initial Enrollment Period, Eligible Persons can enroll themselves and their Dependents during the Annual Open Enrollment Period as defined by the Centers for Medicare & Medicaid Services (CMS).

SPECIAL ENROLLMENT PERIOD

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior Plan was terminated for cause.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth
- Legal adoption
- Placement for adoption
- Marriage

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person or his or her dependents lose minimum essential coverage (but not by failure to pay premiums or due to any situations that would permit Us to rescind coverage), including loss of coverage due to a death that results in the loss of coverage, any termination (other than by reason of gross misconduct) or reduction of employment hours, divorce or legal separation, becoming entitled to Medicare, aging out of dependent coverage.
- The Eligible Person gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption.
- The Eligible Person’s enrollment or non-enrollment in the plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace; The Eligible Person can adequately demonstrate that the qualified health plan in which he or she was previously enrolled violated a material provision of its contract in relation to the individual; The Eligible Person is determined newly eligible or newly eligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing.
reductions, regardless of whether the eligible individual is already enrolled in a qualified health plan. The Eligible Person gains access to new qualified health plans as a result of a permanent move.

When an event takes place (for example, a birth, marriage or determination of eligibility for premium tax credit), coverage begins on the date of the event if We receive the completed application and any required Premium within 60 days of the event unless otherwise noted above.

For newborns, We must receive notification of the event and any required Premium within 60 days after the date of birth. If you fail to notify Us and do not make any required payment beyond the 60 day period, coverage will not continue, unless you make all past due payments with the applicable state allowable interest rate, within one year of the child’s birth. In this case, Benefits are retroactive to the date of birth.

WHEN COVERAGE ENDS

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

We may discontinue this Policy and/or all similar Policies at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, We will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, We will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent’s coverage ends on the date the Subscriber’s coverage ends.

EVENTS ENDING YOUR COVERAGE

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**
  Your coverage ends on the date the Policy ends.

- **You Are No Longer Eligible**
  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 7: Health Services Definitions for complete definitions of the terms “Eligible Person,” “Subscriber,” “Dependent” and “Enrolled Dependent.”

- **We Receive Notice to End Coverage**
  If you enrolled through the Marketplace, your coverage ends on the later of 14 days after the date We receive written notice from you instructing Us to end your coverage, or on the date requested in the notice from the Marketplace. If you enrolled directly with Us, then your coverage ends on the last day of the calendar month in which We receive written notice from the you instructing Us to end your coverage. If you are terminating your coverage because you are newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before the other coverage begins.
OTHER EVENTS ENDING YOUR COVERAGE

When either of the following happens, We will provide advance written notice to the Subscriber that coverage will end on the date We identify in the notice:

- **You Fail to Pay Premiums**
  If you receive an advance premium tax credit (APTC) or reduced cost-sharing and you fail to pay *Premiums* within three months of the date they are due, then We may terminate your coverage as of the last day of the first month of the 3-month grace period. In all other cases, if you fail to pay *Premiums* within 31 days after of the date they are due, then We may terminate your coverage as of the last day of the last month for which We received *Premiums*.

- **Fraud or Intentional Misrepresentation of a Material Fact**
  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a *Dependent*.

During the first two years the *Policy* is in effect, We have the right to demand that you pay back all *Benefits* We paid to you, or paid in your name, during the time you were incorrectly covered under the *Policy*. After the first two years, We can only demand that you pay back these *Benefits* if the written application contained a fraudulent misstatement.

COVERAGE FOR A DISABLED DEPENDENT CHILD

Coverage for an unmarried *Enrolled Dependent* child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the *Enrolled Dependent* child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the *Subscriber* for support.

Coverage will continue as long as the *Enrolled Dependent* is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the *Policy*.

We will ask you to furnish Us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before We agree to this extension of coverage for the child, We may require that a *Physician* chosen by Us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at Our expense. However, We will not ask for this information more than once a year, after the two-year period immediately following the time the child reaches the limiting age.

If you do not provide proof of the child's disability and dependency within 31 days of Our request as described above, coverage for that child will end.

EXTENDED COVERAGE FOR TOTAL DISABILITY
Coverage for a **Covered Person** who is *Totally Disabled* on the date the entire *Policy* is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the *Total Disability*. Benefits will be paid until the earlier of either of the following:

- The *Total Disability* ends.
- Twelve months from the date coverage would have ended when the entire *Policy* was terminated.
- The maximum *Benefit* is paid.
- The succeeding insurer’s *Policy* provides coverage for the condition(s) causing the *Total Disability*.
- The date coverage is or could be obtained under any other group health *Plan*.
- The date the *Policy* ends.

**HOW TO OBTAIN COVERED SERVICES**

*Network Providers* are the key to providing and coordinating your health care services. *Benefits* are provided when you obtain *Covered Health Services* from Providers; however, the broadest *Benefits* are provided for services obtained from *Network Providers*. Services you obtain from any Provider other than a *Network Provider* are considered a Non-Networ**k Service**, unless otherwise indicated in this *Certificate*. Contact Us to be sure that Prior Authorization has been obtained.

**NETWORK SERVICES AND BENEFITS**

If your care is rendered by a Primary Care Physician (PCP), Specialty Care Physicians (SCP), or another *Network Provider*, *Benefits* will be paid at the *Network* level. Regardless of Medical Necessity, no *Benefits* will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another *Network Provider*. All medical care must be under the direction of *Physicians*. We have final authority to determine coverage eligibility for a service based upon our Medical Necessity determination.

*Network Providers* — include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other *Network Providers* as allowed by the *Plan*. The Primary Care Physician is the *Physician* who may provide, coordinate, and arrange your health care services. SCP’s are *Network Physicians* who provide specialty medical services not normally provided by a PCP.

**For services rendered by *Network Providers***:

- You will not be required to file any claims for services you obtain directly from *Network Providers*. *Network Providers* will seek compensation for Covered Services rendered from Us and not from you except for applicable *Coinsurance, Copayments*, and/or *Deductibles*. You may be billed by your *Network Provider(s)* for any non-Covered Services you receive or when you have not acted in accordance with this *Certificate*.
- We do not decide what care you need or will receive. You and your *Physician* make those decisions.

**NON-NETWORK SERVICES**

Services which are not obtained from a *Network Provider* will be considered a Non-Networ**k Service**, unless otherwise indicated in this *Certificate*.

**For services rendered by a Non-Networ**k Provider**, you are responsible for:

- The difference between the actual charge and the *Maximum Allowed Amount* plus any *Deductible* and/or *Coinsurance/Copayments*;
- Services that are not *Medically Necessary*;
• Non-Covered Services;
• Filing claims; and
• Higher cost sharing amounts.

OUT OF SERVICE AREA SERVICES

You may receive Covered Health Services at the In-Network level of benefits when you are traveling outside of Our service area by accessing providers who participate in Our travel/national network.

To find the nearest contracted Provider visit WWW.COMMONGROUNDHEALTHCARE.ORG or call the Member Services Department at the telephone number on your ID card. You must present your ID card to a participating provider and they will submit your claim. If you are out of the service area and an Emergency or urgent situation arises, you should receive treatment right away.

Please note, you may not receive the In-Network level of benefits if the travel/national network Provider provides services within Our service area.

RELATIONSHIP OF PARTIES (PLAN - NETWORK PROVIDERS)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under your Plan. The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider’s facilities.

Your Network Provider’s agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right or cause of action against the Plan based on the actions of a Provider of health care, services, or supplies.

IDENTIFICATION CARD

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Certificate has the right to services or Benefits under this Certificate. If anyone receives services or Benefits to which they are not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or Benefits.

CONTINUITY OF CARE
If your primary care provider (defined as family practice, general practice, internal medicine, pediatrics, geriatrics, OB/GYN, or nurse practitioner or physician assistant practicing in a primary care provider role) terminates their Network participation, you have the right to continue to access that Provider at the In-Network level of Benefits through the end of your Plan year.

If you are undergoing a course of treatment with a Provider who is not a primary care provider as defined above, and that Provider’s participation in the Network terminates, you have the right to continue to access that Provider at the In-Network level of benefits for up to 90 days or the end of your course of treatment, whichever is shorter.

If you are in your 2nd or 3rd trimester of pregnancy and your Provider terminates their Network participation, you have the right to continue to access that Provider for your maternity care at the In-Network level of benefits until the completion of postpartum care.

If you wish to exercise your Continuity of Care rights and continue seeing your Provider for the time period specified above, please contact our Member Services staff, so that we can ensure your claims are paid appropriately. Or our Member Services staff can also assist you in selecting another Network Provider for your care.

Please note that the provisions outlined in this section are not applicable for Providers who are no longer practicing in the service area or who were terminated from this Plan for failure to meet credentialing standards.
COMMON GROUND HEALTHCARE COOPERATIVE
SCHEDULE OF BENEFITS

ACCESSING BENEFITS

You can choose to receive *Network Benefits* or *Non-Network* Benefits.

Network Benefits apply to *Covered Health Services* that are provided by a *Network Provider*. *Emergency Health Services* are paid as *Network Benefits* excluding non-emergency services delivered in an Emergency Room (e.g., out of convenience). For facility charges, these are Benefits for *Covered Health Services* that are billed by a Network facility and provided under the direction of either a Network Provider or Non-Network Provider. *Network Benefits* include *Covered Health Services* provided in a Network facility by a Network or a Non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to *Covered Health Services* that are provided by a Non-Network Provider, or *Covered Health Services* that are provided at a non-Network facility.

You must show your identification card (ID card) every time you request health care services from a Network Provider. If you do not show your ID card, Network Providers have no way of knowing that you are enrolled under a Common Ground Healthcare Cooperative Policy. As a result, they may bill you for the entire cost of the services you receive.

*Additional information about the Network of Providers and how your Benefits may be affected appears at the end of this Schedule of Benefits.***

If there is a conflict between this Schedule of Benefits and any summaries provided to you, this Schedule of Benefits will control.

PRIOR AUTHORIZATION

We require *Prior Authorization* for certain *Covered Health Services* in certain situations in order for Us to help insure that Our members receive the highest quality, most cost-effective services possible.

Network Providers are responsible for obtaining Prior Authorization before they provide these services to you. However, it is ultimately your responsibility to ensure Prior Authorization was obtained. The Services for which Prior Authorization is required are identified below and in the Schedule of Benefits table within each Covered Health Service category.

Before receiving *Covered Health Services* from a Network Provider, you may want to contact Us to verify that the Hospital, Physician and other providers are Network Providers and that they have obtained the required Prior Authorization. You can contact Us by calling the telephone number for the Member Services Department on your ID card.

*When you choose to receive certain Covered Health Services from Non-Network Providers, you are responsible for obtaining Prior Authorization before you receive these services.***

Note that your obligation to obtain Prior Authorization is also applicable when a Non-Network Provider intends to admit you to a Network facility or refers you to other Network Providers. Once you have
obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

If you fail to obtain written Prior Authorization for designated services, eligible charges will be reduced by 50% up to a maximum penalty of $1500. The 50% penalty will apply first, before Deductibles, Coinsurance, or any other Plan payment or action. The 50% penalty does not apply toward your Maximum Out-of-Pocket.

To obtain Prior Authorization, call the Member Services Department at the phone number listed on your ID card. This call starts the utilization review process.

The utilization review process is 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. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

COVERED HEALTH SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

The Prior Authorization request must be received by Us at least fifteen (15) business days prior to the anticipated date of your service/procedure. Please note that urgent or emergency admissions, Prior Authorization must be obtained within 24 hours of the admission or the next business day. Approval of an elective inpatient admission to a facility is required prior to the elective services being received. Please note that a verbal request for Prior Authorization does not guarantee approval. We will notify you in writing of the decision regarding a determination for elective outpatient services.

If your Provider determines that additional care beyond the services specified or the length of time originally authorized is medically indicated, We must be contacted to request an extension of the original authorization. You and your Provider will be notified whether the request for an extension is approved or denied. 

Prior Authorization must be obtained regardless of whether Common Ground Healthcare Cooperative is your primary or secondary health insurance carrier. Prior Authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

- Ambulance — non-emergency air and ground
- Any procedure that could be considered cosmetic
- Autism Spectrum Disorder Services
- Biofeedback
- Botox injections
- Chemotherapy — outpatient and inpatient
- Clinical trials
  - Cochlear Implants
- Congenital heart disease surgery
- Dental services - accidental
- Dental/Anesthesia - Hospital Ambulatory Surgery Services
- Dialysis
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). Some examples include but are not limited to:
  - Continuous glucose monitoring device
  - CPAP machine for sleep apnea
  - Insulin pump (not for supplies only)
  - Feeding pump
  - Transcutaneous Electronic Nerve Stimulator (TENS)
  - Infusion pumps
  - Hospital bed(s)
  - Wheelchair(s)
  - Ventilator(s)
  - Continuous Passive Motion (CPM) machines
  - Pneumatic compressors for Lymphedema
  - Wound V.A.C. (Vacuum-Assisted Closure)

- Genetic Testing, including BRCA Genetic Testing except as authorized under Section 17 (below)
- Habilitation services
- Home health care
- Hospital inpatient care (not including observation stay which is less than two (2) midnights)
- Mental Health Services - inpatient services only
- MRI, MRA, PET, CT Scans and Echocardiogram
- Occupational therapy
- Prescription Drugs — As noted in the Prescription Drug Formulary, any drug requiring Prior Authorization for Step Therapy (ST) or for quantity limit (QL) must be approved by Catamaran at 855-577-6545
- Physical therapy
- Prosthetics
- Pulmonary or cardiac rehabilitation
- Radiation therapy — outpatient and inpatient
- Reconstructive procedures, including breast reconstruction surgery following mastectomy
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services
- Specialty Medications — Contact Catamaran at 855-577-6545
- Speech Therapy
- **Substance Use Disorder Services** - inpatient services only
- Surgery - Outpatient hospital, free standing surgical center and ambulatory surgery centers (does not include physician office procedures).
- Temporomandibular joint disorder services
- Transplants

In some situations you may need medical attention before the written **Prior Authorization** process can take place. When circumstances such as these occur please call the Member Services Department by the next business day at the telephone number on your ID card.

As We determine, if one or more alternative health services that meets the definition of a **Covered Health Service** in the **Certificate** under **Section 7: Health Services Definitions** are clinically appropriate and equally effective for prevention, diagnosis or treatment of a **Sickness, Injury, Mental Illness**, substance use disorder or their symptoms, We reserve the right to adjust **Eligible Expenses** for identified **Covered Health Services** based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

For all other services, when you choose to receive services from Non-Network Providers, We urge you to confirm with Us that the services you plan to receive are **Covered Health Services**. That's because in some instances, certain services may not otherwise meet the definition of a **Covered Health Service** if delivered by a non-Network Provider, and therefore are excluded. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time **Prior Authorization** is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, Our final coverage determination will be modified to account for those differences, and We will only pay **Benefits** based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a **Medically Necessary Covered Health Service**, you will be responsible for paying all charges and no **Benefits** will be paid.

**SPECIAL NOTE REGARDING MEDICARE**

If you are enrolled in **Medicare** on a primary basis (**Medicare** pays before We pay **Benefits** under the **Policy**), the **Prior Authorization** requirements do not apply to you. Since **Medicare** is the primary payer, We will pay as secondary payer as described in **Section 5: Coordination of Benefits**. You are not required to obtain authorization before receiving **Covered Health Services**.

**ELIGIBLE EXPENSES**

**Eligible Expenses** are the amount We determine that We will pay for **Benefits**. For **Network Benefits**, you are not responsible for any difference between **Eligible Expenses** and the amount the provider bills. For **Non-Network Benefits**, you are responsible for paying, directly to the Non-Network Provider, any difference
between the amount the Non-Network Provider bills you and the amount We will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with Our reimbursement Policy guidelines.

If one or more alternative health services that meets the definition of Covered Health Service in the Certificate under Section 7: Health Services Definitions are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, We reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

When Covered Health Services are received from a Network Provider, Eligible Expenses are Our contracted fee(s) with that Provider. When Covered Health Services are received from a Non-Network Provider, Eligible Expenses is the amount the Policy generally pays for non-Network services without regard to Copayments, Deductibles and/or Coinsurance or are determined, based on available data resources of competitive fees in that geographic area.

PROVIDER NETWORK

We arrange for health care providers to participate in a Network. Network Providers are independent practitioners. They are not Our employees. Although it is your responsibility to select your Provider, Our Member Services representatives are happy to assist with finding the right Provider for you.

Our credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a Provider. A Provider's status may change. A directory of Network Providers is available online at WWW.COMMONGROUNDHEALTHCARE.ORG or by calling the Member Services Department at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network Provider. The Network of Providers is subject to change. Or you might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another Network Provider to get Network Benefits. Our Member Services Department would be happy to discuss your options and assist with the choice of Provider.

If you are currently undergoing a course of treatment utilizing a Non-Network Provider or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement Policy or would like help determining whether you are eligible for transition of care Benefits, please contact the Member Services Department at the telephone number on your ID card.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to your Network Provider directory or contact Us for assistance.

DESIGNATED FACILITIES AND DESIGNATED PHYSICANS
If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a Non-Network facility (regardless of whether it is a Designated Facility) or other Non-Network Provider, Network Benefits will not be paid.

HEALTH SERVICES FROM NON-NETWORK PROVIDERS PAID AS NETWORK BENEFITS

If specific Covered Health Services are not available from a Network Provider, you may be eligible for Network Benefits when Covered Health Services are received from Non-Network Providers. In this situation, your Network Provider will notify us and, if we confirm that care is not available from a Network Provider, we will work with you and your Network Provider to coordinate care through a Non-Network Provider.
SECTION 1: COVERED HEALTH SERVICES

BENEFITS FOR COVERED HEALTH SERVICES

Benefits are available only if all of the following are true:

- **Covered Health Services** and **Benefits** are subject to the conditions, exclusions, limitations and provisions of this Certificate including any attachments or endorsements.

- **Covered Health Services** must be **Medically Necessary** and not Experimental/Investigational (except as described in the Clinical Trial section below). The fact that your Provider prescribes or recommends a service, treatment or supply does not make it **Medically Necessary** or a **Covered Health Service** and does not guarantee payment.

- **Covered Health Services** are received while the **Policy** is in effect.

- **Covered Health Services** are received prior to the date that any of the individual or group termination conditions listed in **When Coverage Ends** occurs.

- The person who receives **Covered Health Services** is a **Covered Person** and meets all eligibility requirements specified in the **Policy**.

- This section describes **Covered Health Services** for which **Benefits** are available. Please refer to the **Schedule of Benefits** for details about:
  
  - The amount you must pay for these **Covered Health Services** (including any **Annual Deductible**, **Copayment** and/or **Coinsurance**). Please note that your responsibility will be different if you seek services from a **Network** physician or facility versus a **Non-Network** physician or facility.
  
  - Any limit that applies to these **Covered Health Services** (including visit, day and dollar limits on services and/or any Maximum **Policy** Benefit).
  
  - Any limit that applies to the amount you are required to pay in a year (**Out-of-Pocket Maximum**).
  
  - Any responsibility you have for obtaining **Prior Authorization** or notifying Us.

Please note that in listing services or examples, when We say "this includes," it is not Our intent to limit the description to that specific list. When We do intend to limit a list of services or examples, We state specifically that the list "is limited to."

1. AMBULANCE SERVICES

*Emergency* ambulance transportation by a licensed ambulance service (either ground or air ambulance) is provided to the nearest **Hospital** where *Emergency Health Services* can be performed.

- **Non-Emergency** ambulance transportation by a licensed ambulance service (either ground or air ambulance, as We determine appropriate) between facilities when the transport is any of the following:
  
  - From a **Non-Network Hospital** to a **Network Hospital**.
To a Hospital that provides a higher level of care that was not available at the original Hospital.

To a more cost-effective acute care facility.

From an acute facility to a sub-acute setting.

2. AUTISM SPECTRUM DISORDER SERVICES

The following definitions apply for purposes of Autism Spectrum Disorders:

“Autism Spectrum Disorders” means any of the following:

- Autism disorder.
- Asperger’s syndrome.
- Pervasive development disorder not otherwise specified.

"Intensive level services" means evidence-based behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social and behavioral deficits associated with that disorder. Intensive level services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual’s therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

"Non intensive level services" means evidence-based therapy that occurs after the completion of treatment for Intensive level services and that is designed to sustain and maximize gains made during treatment with Intensive level services or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Intensive Level Services

Note: Benefits for intensive-level services begin after the Enrolled Dependent child turns two years of age but prior to turning nine years of age.

Benefits are provided for evidence-based behavioral intensive level therapy for an insured with a verified diagnosis of Autism Spectrum Disorder, the majority of which shall be provided to the Enrolled Dependent child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive level provider or a qualified intensive level professional that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.

- Implemented by qualified providers, qualified professional, qualified therapists or qualified paraprofessionals.

- Provided in an environment most conducive to achieving the goals of the Enrolled Dependent child’s treatment plan.
• Included training and consultation, participation in team meeting and active involvement of the Enrolled Dependent child's family and treatment team for implementation of the therapeutic goals developed by the team.

• The Enrolled Dependent child is directly observed by the qualified intensive level provider or qualified intensive level professional at least once every two months.

• Beginning after the Enrolled Dependent child is two years of age and before the Enrolled Dependent child is nine years of age.

Intensive level services will be covered for up to four cumulative years. We may credit against any previous intensive level services the Enrolled Dependent child received against the required four years of intensive level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for Autism Spectrum Disorders that was provided to the Enrolled Dependent child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the Enrolled Dependent child for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

Travel time for qualified providers, supervising providers, professionals, therapists, paraprofessionals or behavioral analysts is not included when calculating the number of hours of care provided per week. Travel time is not a covered expense.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

We will cover services from a qualified therapist when services are rendered concomitant with intensive level evidence-based behavioral therapy and all of the following apply:

• The qualified therapist provides evidence-based therapy to an Enrolled Dependent child who has a primary diagnosis of an Autism Spectrum Disorder.

• The Enrolled Dependent child is actively receiving behavioral services from a qualified intensive level provider or qualified intensive level professional.

• The qualified therapist develops and implements a treatment plan consistent with their license and this section.

Non-Intensive Level Services
Non-intensive Level Services will be covered for an Enrolled Dependent child with a verified diagnosis of Autism Spectrum Disorder for non-intensive level services that are evidence-based and are provided to an Enrolled Dependent child by a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following conditions:

• After the completion of intensive level services and designed to sustain and maximize gains made during intensive level services treatment.
To an Enrolled Dependent child who has not and will not receive intensive level services but for whom non-intensive level services will improve the Enrolled Dependent child's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified provider, qualified professional or qualified therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified professionals, qualified therapist or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goal of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the Enrolled Dependent child's family in order to implement the therapeutic goals developed by the team.
- Provided treatment is supervised by qualified providers, professionals, therapists and paraprofessionals.

Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapists, qualified paraprofessionals or qualified behavioral analysts is not included when calculating the number of hours of care provided per week. Travel time is not a covered expense.

Intensive level and non-intensive level services include but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under the Autism Spectrum Disorders (this is not an all-inclusive list):

- Services which are not Evidence-Based.
- Acupuncture.
- Animal-based therapy including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Custodial or respite care.
• Hyperbaric oxygen therapy.
• Special diets or supplements.
• Travel time.
• Pharmaceuticals and Durable Medical Equipment.
• Therapy, treatment or services, including room and board, provided to a Eligible Person who is staying in a residential treatment center, inpatient treatment or day treatment facility.
• Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of a Eligible Person’s home.
• Claims we have determined are fraudulent.
• Treatment provided by parents or legal guardians who are otherwise Qualified Providers, Qualified Supervising Providers, Therapists, Qualified Professionals or Paraprofessionals for treatment provided to their own children.

3. BIOFEEDBACK
Biofeedback can be defined as a training technique that utilizes monitoring instruments to detect and amplify internal physiological processes, and presents this ordinarily unavailable information by audio and/or visual means to patients. This information is usually displayed in a quantitative manner and used by the patients to learn specific tasks.

Biofeedback is covered only for the treatment of:
• Headaches.
• Spastic Torticollis.
• Urinary Incontinence.
• Post-traumatic stress disorder.
4. BOTOX INJECTIONS

The use of botulinum toxin is a *Covered Health Service* only when provided in the treatment of the following disorders associated with spasticity or dystonia:

- Blepharospasm
- Cerebral palsy
- Facial nerve (VII) dystonia
- Hemifacial spasm
- Hereditary spastic paraparesis
- Idiopathic torsion dystonia
- Multiple sclerosis
- Neuromyelitis optica
- Organic writer's cramp
- Orofacial dyskinesia (i.e., jaw closure dystonia)
- Schilder's disease
- Spasmodic dysphonia or laryngeal dystonia (a disorder of speech due to abnormal control of the laryngeal muscles present only during the specific task of speaking)
- Spastic hemiplegia
- Spasticity related to stroke, spinal cord injury, or traumatic brain injury
- Symptomatic torsion dystonia
- Other forms of upper motor neuron spasticity
- The use of botulinum toxin in the treatment of achalasia.
- The use of botulinum toxin in the treatment of anal fissures.
- The use of botulinum toxin in the treatment of significant drooling in individuals who are unable to tolerate scopolamine.
- The use of botulinum toxin in the treatment of migraines.

5. CARDIAC REHABILITATION

A program for patients with heart disease aimed at ensuring patients preserve or resume best possible health and functional capacity. Usually includes an exercise training component.

**Coverage Provisions:**

- 36 session limit per calendar year
- Cardiac rehabilitation is covered if there is a recent history of:
  - A heart attack
  - Coronary bypass surgery
  - Onset of angina pectoris
  - Heart valve surgery
  - Onset of decubital angina
  - Percutaneous transitional angioplasty
  - Cardiac transplant

6. CHIROPRACTIC SERVICES

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations and treatment.
7. CLINICAL TRIALS

Routine patient care costs incurred during participation in a qualifying clinical trial.

Routine patient care costs includes items, services, and drugs provided to you in connection with a qualified clinical trial that would be covered under this Plan if you were not enrolled in such qualified clinical trial. In order to qualify you must be eligible to participate in the qualified clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either (a) the referring participating provider has concluded that your participation in the qualified clinical trial is appropriate according to the trial protocol or (b) you and/or your physician provide medical and scientific information establishing that your participation in the qualified clinical trial is appropriate according to the trial protocol. Routine patient care does not include the investigational item, devise, or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in your direct clinical management; and/or a service that is clearly inconsistent with widely accepted and established standards of care for your diagnosis.

A qualifying clinical trial means any phase of a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

1. The study or investigation is approved or funded (including funding through in-kind contributions) by one or more of the following:

   a. The National Institutes of Health.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the above four entities or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

8. COCHLEAR IMPLANT
Cochlear implant is a device for individuals with severe-to-profound hearing loss who only receive limited benefit from amplification with hearing aids. A cochlear implant provides direct electrical stimulation to the auditory nerve, bypassing the usual transducer cells that are absent or nonfunctional in deaf cochlea.

The basic components of a cochlear implant include both external and internal components. The external components include a microphone, an external sound processor, and an external transmitter. The internal components are implanted surgically and include an internal receiver implanted within the temporal bone and an electrode array that extends from the receiver into the cochlea through a surgically created opening in the round window of the middle ear.

- Subject to any coinsurance and/or deductible limits shown in your schedule of benefits

9. CONGENITAL HEART DISEASE SURGERIES

Congenital heart disease (CHD) surgeries which are ordered by a Physician include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of Fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician Fees for Surgical and Medical Services.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact Us at the telephone number on your ID card for information about these guidelines.

10. CONTRACEPTIVE MEDICATIONS AND DEVICES

Drugs or devices approved by the U.S. Food and Drug Administration to prevent pregnancy.

Contraceptive Medications and Devices for females listed on our Prescription Drug Formulary which include:

- Contraceptive oral medications
- FDA-approved intrauterine contraceptive system (also known as an IUD*)
- Flexible birth control vaginal ring
- Hormone-releasing birth control implant
- Contraceptive patch
- Intrauterine contraceptive (IUC)
- Hormone-releasing IUD (intrauterine device)
- Subcutaneous injection

- All contraceptive medications and devices defined within the formulary as preventive will be dispensed at no cost to the member.
11. DENTAL SERVICES — ACCIDENT ONLY

Dental services when all of the following are true:

1. Treatment is necessary because of accidental damage to the teeth and/or gums.

2. Dental services are received from a Doctor of Dental Surgery, Oral Surgeon or Doctor of Medical Dentistry.

3. The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

**Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.**

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

- Treatment must be completed within 12 months of the accident.

**Benefits for treatment of accidental Injury are limited to the following:**

- *Emergency* examination.

- Necessary diagnostic X-rays.

- Temporary splinting of teeth.

- Endodontic (Root Canal) treatment.

- Prefabricated post and core.

- Extractions.

- Anesthesia.

- Post-traumatic crowns if such are the only clinically acceptable treatment.

- Replacement of lost teeth due to the *Injury* by implant, dentures or bridges.

12. DENTAL/ANESTHESIA SERVICES — HOSPITAL OR AMBULATORY SURGERY SERVICES

*Hospital* and ambulatory surgery center charges provided in conjunction with dental care, including anesthetics provided, if any of the following applies:

- The *Covered Person* has a chronic disability.

- The *Covered Person* has a medical condition requiring hospitalization or general anesthesia for dental care.

13. DIABETES SERVICES

**Benefits** are provided for medical supplies, services, and equipment used in the treatment of diabetes. Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical
needs of the Covered Person. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described further under the Outpatient Prescription Drug.

**Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care**
Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

14. Diagnostic Testing
Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not covered services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a covered transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician’s office.

15. Durable Medical Equipment
Benefits under this section include Durable Medical Equipment provided to you by a Physician. Durable Medical Equipment that meets each of the following criteria:

- The equipment, supply or appliance is a Covered Health Service.
- The continued use of the item is Medically Necessary.
- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Not consumable or disposable except as required as a component of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece We have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as crutches and a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Cardiac, neonatal and sleep apnea monitors.
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (air conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical benefit categories in this Certificate, as required by Wisconsin insurance law.
- Colostomy supplies.
Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury.

Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented. Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

If you have any question regarding whether a specific Durable Medical Equipment is covered call the Member Services number on the back of your ID Card.

16. EMERGENCY HEALTH SERVICES — OUTPATIENT

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. Medically Necessary services that We determine meet the definition of Emergency Care will be covered whether rendered by Network or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network Provider however; the Member may be responsible for charges between the Non-Network Provider charge and the Maximum Allowed Amount.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

17. GENETIC TESTING AND COUNSELING

Benefits under this section include:

- Counseling if associated with a covered and approved test or it is for the purpose of determining if a specific genetic test is appropriate.
- BRCA Genetic Test (High risk Breast and/or Ovarian Cancer Genetic test).
- The genetic test is not considered experimental or investigational.

18. HABILITATIVE SERVICES

The Patient Protection and Affordable Care Act (PPACA) requires coverage for essential health Benefits, including coverage for Habilitative Services in individual and small group products. Habilitation Services are defined as those health care services that help a person keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).
Coverage Provisions:

- All of the following must be met for coverage of Habilitative Services not related to Autism Spectrum disorder:
  - Treatment must be evidence-based physical or occupational therapy provided by an appropriately licensed therapist under the direction of a physician or advanced practice nurse in accordance with a written treatment plan established or certified by the treating physician or advanced practice nurse.
  - One of the following diagnoses:
    - developmental delay
    - developmental coordination disorder
    - mixed developmental disorder
    - developmental speech or language disorder
  - Habilitation Services and diagnoses not specifically listed above are not covered, including but not limited to respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind.

19. HEARING AIDS

Benefits are available for hearing aids, for Covered Persons who are certified as deaf or hearing impaired by either a Physician or audiologist licensed under Wisconsin law. Related treatment includes services, diagnoses, surgery, and therapy provided in connection with the hearing aid and/or cochlear implant.

Coverage of hearing aids is subject to the limit listed in the Schedule of Benefits. Please note that Covered Health Services do not include the cost of batteries or cords.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this Certificate, only for Covered Persons who have either of the following:

- Craniofacial anomalies which preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

20. HOME HEALTH CARE

Services received from a Home Health Agency that meet both of the following criteria:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:
• It must be delivered or supervised by licensed technical or professional medical personnel (e.g., OT, ST, PT or a social worker) in order to obtain the specified medical outcome, and provide for the safety of the patient.

• It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

• It requires clinical training in order to be delivered safely and effectively.

• It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

### 21. HOSPICE CARE

Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care is recommended by your Physician. Care may be provided in the home or at a hospice facility. To be eligible for Benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person. Benefits are available when hospice care is received from a licensed hospice agency.

Those covered services and supplies listed below are covered if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the exclusions section for services that are not covered.

• Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
• Short-term inpatient facility care when required in periods of crisis or as respite care.
• Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
• Social services and counseling services provided by a licensed social worker.
• Nutritional support such as intravenous hydration and feeding tubes.
• Physical therapy, occupational therapy, speech therapy and respiratory therapy.
• Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your Physician and the hospice medical director must certify that you are terminally ill and generally have less than six months to live, and (2) your physician must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional covered services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in hospice. Benefits for these additional covered services, which are described in other parts of this Policy, are provided as set forth in
other parts of this Policy.

22. HOSPITAL — INPATIENT STAY
Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:
- Room and board in a Semi-private Room (a room with two or more beds) or a room in a special care unit.
- Ancillary Services and supplies - services received during the Inpatient Stay including operating, delivery and treatment rooms, equipment, prescription drugs, diagnostic and therapy services
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

23. INPATIENT REHABILITATION
Benefits under this section include:
- Individual has a new (acute) medical condition or an acute exacerbation of a chronic condition that has resulted in a significant decrease in functional ability such that they cannot adequately recover in a less intensive setting; AND
- Individual's overall medical condition and medical needs either identify a risk for medical instability or a requirement for physician and other medical professional involvement generally not available outside the Hospital inpatient setting; AND
- The individual is capable of actively participating in a rehabilitation program, as evidenced by a mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands
- Individual's mental and physical condition prior to the illness or injury indicates there is significant potential for improvement
- The necessary rehabilitation services must be prescribed by a Physician, and require close medical supervision and skilled nursing care with the 24-hour availability of a nurse and physician who are skilled in the area of rehabilitation medicine

24. KIDNEY DISEASE TREATMENT
Inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-related services.

25. LABORATORY SERVICES
Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Clinic or Alternate Facility include:
- Lab tests when an appropriate diagnosis is present.
- Infertility diagnostic tests unless a diagnosis of infertility has already been established. If a diagnosis has been established, no additional fertility testing is covered.
- All services must be ordered by a licensed Physician.

Laboratory tests for preventive care are described under Preventive Care Services.
26. MEDICAL SUPPLIES

*Benefits* under this section include:

- Tubings and masks when used with approved and covered *Durable Medical Equipment (DME)* as described under the *Durable Medical Equipment (DME)* section.
- Diabetic Supplies under Diabetic Services section.
- Ostomy Supplies under Ostomy Supplies section.
- Urinary Catheter Supplies under Urinary Catheter section.

27. MENTAL HEALTH SERVICES

*Mental Health Services* include those received on an inpatient or *Transitional Care* basis in a *Hospital* or an *Alternate Facility*, and those received on an outpatient basis in a provider's office or at an *Alternate Facility*.

*Benefits* for *Mental Health Services* include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- *Partial Hospitalization/Day Treatment*.
- *Intensive Outpatient Treatment*.
- Services at a *Residential Treatment Facility*.
- Individual, family and group therapeutic services.
- Crisis intervention.

The *Mental Health/Substance Use Disorder Designee*, who will authorize the services, will determine the appropriate setting for the treatment. If an *Inpatient Stay* is required, it is covered on a *Semi-private Room* basis. Referrals to a *Mental Health Services* provider are at the discretion of the *Mental Health/Substance Use Disorder Designee*, who is responsible for coordinating all of your care.

28. NEWBORN BENEFITS

Newborn *Benefits* include the following services:

- Nursery room, board and care.
- Routine and preventive exam or services when received by the newborn before release from the *Hospital*.
- Circumcision when rendered prior to discharge from the *Hospital*.
• Plastic surgery, in order to reconstruct or restore function to a body part with a functional defect present at birth.

29. NUTRITION & MEDICAL NUTRITION EDUCATION

Benefits under this section include medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

• Nutritional education is required for a disease in which patient self-management is an important component of treatment.
• There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

30. ORAL SURGERY

Benefits for oral surgery are limited to the following:

• Surgical removal of impacted teeth.
• Excision of tumors, cysts and abscess of the jaws, cheeks, tongue, roof and floor of the mouth.
• Apicoectomy — Excision of apex of tooth root.
• Excision of exostosis of the jaws and hard palate.
• Frenectomy - Incision of any mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue.
• Alveoloplasty – the leveling of structures supporting teeth or the purpose of fitting dentures.
• Residual root removal.
• Removal of exposed roots.
• Gingival procedures:
  a. Gingivectomy or Gingivoplasty – Excision of loose gum tissue to eliminate infection.
  b. Gingival curettage.
  c. Gingival flap procedure, including root planing.
• Osseous surgery.
• Alveoloplasty – the leveling of structures supporting teeth or the purpose of fitting dentures.

31. OSTOMY SUPPLIES

Benefits for ostomy supplies are limited to the following:

• Pouches, face plates and belts.
• Irrigation sleeves, bags and ostomy irrigation catheters.
• Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

32. PARENTERAL AND ENTERAL NUTRITION IN THE HOME

Benefits for oral enteral and parenteral nutrition are available for individuals who meet the following criteria:

• The product must be medical food for oral or tube feeding;
• The product must be the primary source of nutrition, i.e. more than half the intake for the individual;
• The product must be labeled and used for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements to avert the development of a serious physical or mental disability or to promote normal development and function;
• The product must be used under the supervision of a physician or nurse practitioner, or ordered by a registered dietician upon referral by a healthcare provider authorized to prescribe dietary treatments.

33. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY — OUTPATIENT

Benefits for Physical Therapy, Occupational Therapy and/or Speech Therapy (outpatient) are limited to the following:

• For speech and occupational therapy for autism, please refer to the Autism section.
• For speech and occupational therapy for habilitative services, please refer to the Habilitative Services section.
• Each therapy, OT, PT and ST have a 20 visit limit each per calendar year under this benefit.
• The care must be for restoration of a function or ability that was present and has been lost due to bodily injury or sickness.
• Therapy must be necessitated by a medical condition and not be primarily educational in nature.

34. PHARMACEUTICAL PRODUCTS — OUTPATIENT

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician’s office, or in a Covered Person’s home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by Us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.
35. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

36. PHYSICIAN’S OFFICE SERVICES — SICKNESS AND INJURY

Services provided in a Physician’s office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician’s office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician’s office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician’s office are described under Preventive Care Services.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician’s office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

37. PODIATRY SERVICES

Benefits for podiatry services are limited to the following Covered Health Services:

- Treatment of medical problems of the feet, including medical or surgical treatment related to disease, injury, or defects of the feet;
- Medically Necessary routine foot care for Members with certain chronic conditions such as diabetes.

38. PREGNANCY — MATERNITY SERVICES

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor, if Medically Necessary, when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify
Us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

39. PREVENTIVE CARE SERVICES

Preventive care services provided on an outpatient basis at a Physician’s office or an Alternate Facility encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

CGHC covers preventive care services as required by the Patient Protection and Affordable Care Act (PPACA), without charging a deductible, coinsurance or copayment when these services are provided by a IN-Network provider in a primary setting. CGHC covers these services consistent with the recommendations and guidelines of the United States Preventive Service Task Force (USPSTF) or other regulatory organizations based on age, health status, gender guidelines, and medical evidence. Consult your doctor for your specific preventive health recommendations.

Preventive Health Services for Adults:
- Abdominal Aortic Aneurysm One time Screening
  - Men aged 65-75 with a history of smoking
- Alcohol Misuse Screening & Counseling
- Aspirin Use
  - If ordered by physician and a prescription is received from the provider
  - Prescription filled using pharmacy benefit
  - Female ages 55-79; Male ages 45-79
- Blood Pressure Screening — This is part of a preventive care wellness exam or office visit
- Cholesterol Screening — Age 20 years and older
- Colorectal Cancer Screening- — Age 50 and older includes colonoscopy, sigmoidoscopy, test for occult blood
- Prostate Cancer Screening — Men aged 40 years and older
- Depression Screening
- Diabetes Type 2 Screening
- Diet Counseling
- Vaccinations/Immunizations:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster-Shingles
  - Human Papilloma Virus (HPV)
  - Influenza -flu shot
  - Meningococcal
  - Pertussis
  - Pneumococcal - Pneumonia
Tetanus
Varicella-Chicken Pox

- Obesity Screening (Screening and Counseling) in Adults
- Tobacco Use Screening & Interventions in Adults and Pregnant Women

**Preventive Health Services for Women:**

- Prenatal Test/Screening:
  - Anemia Screening
  - Bacteriuria Screening
- Breast Cancer Genetic Test Counseling and Evaluation for BRCA
- BRCA Testing & Screening — Must have a family history of ovarian or breast cancer
- Breast Cancer Mammography Screening — Female 40 years and older
- Breast Pumps — If ordered by a licensed professional after the birth of a child. Coverage is limited to one standard manual, simple breast pump or one basic single electric pump. A hospital-grade model is not covered.
- Breastfeeding Comprehensive Support & Counseling
- Cervical Cancer Screening-Pap Smear — Female ages 21-64
- Chemoprevention of Breast Cancer Counseling — Females at risk for breast cancer
- Chlamydia Infection Screening
  - Female and under 25 years if sexually active
  - Female and 25 years and older with multiple sex partners, pregnant or of child bearing years
- Contraception — See medications and devises listed on our *Prescription Drug* formulary
- Sterilization — Tubal Ligation
- Domestic & Interpersonal Violence Screening & Counseling
- Folic Acid
  - If ordered by physician and a prescription is received from the provider
  - Prescription filled using pharmacy benefit
  - Pregnant females or of child bearing age
- Gestational Diabetes Screening — Pregnant females
- Gonorrhea Screening — Females who are sexually active or pregnant
- Hepatitis B Screening — Pregnant females
- HIV Screening — Pregnant females
- Human Papilloma Virus (HPV) DNA Test
- Osteoporosis Screening - Bone Density
- Rh Incompatibility Screening — Pregnant females
- Rubella Screening by History of Vaccination or by Serology — Pregnant females
- Syphilis Screening — Pregnant females or if at risk for syphilis Infection
- Well-Women Visit
- Well-Women Prenatal Visits — Pregnant females

**Childhood Preventive Services:**

- Physician Visit (well-child/well-baby/health check)
- Autism Screening
- Behavioral Assessments
- Blood Pressure Screening
- Cervical Dysplasia Screening — Females under 18 and sexually active
- Depression Screening in Children and Adolescents
- Developmental Screening — Prenatal through age 21
- Dyslipidemia Screening — Ages 2 through 21
- Gonorrhea preventive Medication
- Hearing Screening
- Height, Weight and Body Mass Index Measurements
- Hematocrit or Hemoglobin Screening (Anemia)
- Hemoglobinopathies or sickle cell screening
- Childhood Vaccinations/Immunizations:
  - Diphtheria
  - Haemophilus Influenza Type B (HIB)
  - Hepatitis A
  - Hepatitis B
  - Human Papilloma Virus
  - Inactivated Polio Virus
  - Influenza Shot
  - Measles
  - Mumps
  - Rubella
  - Meningococcal-Child
  - Pneumococcal - Pneumonia
  - Rotavirus
  - Varicella-Chicken Pox
- Iron Supplements
  - If ordered by physician and a prescription is received from the provider
  - Prescription filled using pharmacy benefit
- Lead Poisoning Screening
- Medical History
- Obesity Screening and Counseling in Children and Adolescents
- Tobacco Prevention Interventions for Children & Adolescents
- Oral Health risk assessment
- Sexually Transmitted Infection (STI) Prevention Counseling & Screening
- Tuberculin Testing (TB skin test)
- Skin Cancer Prevention Counseling
- Vision Screening in Children

Newborn Screening (0-90 Days):
- Hypothyroidism Screening
- Phenylketonuria (PKU) Screening
- Sickle Cell Screening
- Metabolic Screening

Preventive care services may not be performed for the primary reason of diagnosing or treating an illness or injury.
More information about the preventive services coverage required under the Affordable Care Act can be found at http://www.healthcare.gov/prevention/index.html.

40. PROSTHETIC DEVICES
External prosthetic devices that replace a limb or a body part, limited to:
- Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
- If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, We will pay only the amount that We
would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

- The prosthetic device must be ordered or provided by, or under the direction of a Physician.
- Breast prosthesis as required by the Women’s Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Benefits are available for repairs and replacement, except that:
  - There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
  - There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, We will pay only the amount that We would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

41. PULMONARY REHABILITATION

Benefits for pulmonary rehab are limited to 36 sessions per calendar year, must be approved and meet Prior Authorization criteria.

42. RECONSTRUCTIVE PROCEDURES

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Please note that Benefits for reconstructive procedures include breast reconstruction following mastectomy including of the non-affected breast to achieve symmetry and nipple and areola reconstruction/tattoo. Other services required by the Women’s Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

43. REHABILITATION SERVICES AND HABILITATIVE SERVICES — OUTPATIENT THERAPY, MANIPULATIVE TREATMENT AND CHIROPRACTIC

Short-term outpatient rehabilitation services, limited to:
• Physical therapy.
• Occupational therapy. This does not include services as described under *Autism Spectrum Disorder Services* in this section.

• *Manipulative Treatment*.
• Speech therapy. This does not include services as described under *Autism Spectrum Disorder Services* in this section.
• Cardiac rehabilitation therapy.
• Post-cochlear implant aural therapy.
• Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a *Physician* or by a licensed therapy provider. *Benefits* under this section include rehabilitation services provided in a *Physician’s* office or on an outpatient basis at a Hospital or *Alternate Facility*.

*Benefits* can be denied or shortened for *Covered Persons* who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. *Benefits* can be denied or shortened for *Covered Persons* who are not progressing in goal-directed *Manipulative Treatment* or if treatment goals have previously been met. *Benefits* under this section are not available for maintenance/preventive *Manipulative Treatment*.

Please note that We will pay *Benefits* for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing. For speech therapy with relation to *Autism Spectrum Disorders*, please refer to the services described under *Autism Spectrum Disorder Services* in this section. We will pay *Benefits* for cognitive rehabilitation therapy only when *Medically Necessary* following a post-traumatic brain *Injury* or cerebral vascular accident.

### 44. REPRODUCTIVE SERVICES

*Benefits* for reproductive services include:

- Female Contraception — See coverage specifics under *Contraceptive Medications and Devices* section.
- Tubal Ligation—Meets *Prior Authorization* criteria and is approved.
- Vasectomy in *Physician’s* office (*Prior Authorization* required if ambulatory surgery or inpatient).

### 45. SCOPIC PROCEDURES — OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or *Alternate Facility* or in a *Physician’s* office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include but not limited to colonoscopy, sigmoidoscopy, endoscopy (Upper GI), Endoscopic Retrograde Cholangiopancreatography (ERCP) and Ureteroscopy.
Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)

When these services are performed for preventive screening purposes, Benefits are described under Preventive Care Services.

46. SKILLED NURSING FACILITY

Services and supplies provided in a Skilled Nursing Facility. Benefits are available for:

- Limited to 30 days per calendar year.
- Room and board in a Semi-private Room (a room with two or more beds).
- Ancillary Services and supplies — services received during the Inpatient Stay including prescription drugs, diagnostic and therapy services.

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered exclusively for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.

Benefits can be denied or discontinued for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

47. SUBSTANCE USE DISORDER SERVICES
Substance Use Disorder Services include those received on an inpatient or Transitional Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider’s office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:
- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility. (Note: Does not include halfway houses.)
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

48. SURGERY — OUTPATIENT
Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician’s office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy. Examples of surgical procedures performed in a Physician’s office are mole removal and ear wax removal.

Benefits under this section include:
- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

49. TEMPOROMANDIBULAR JOINT DISORDER SERVICES
Diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular joint disorders (TMJ) and associated muscles, if all of the following apply:

- The condition is caused by congenital, developmental or acquired deformity, disease or Injury.
- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- Benefits are not available for cosmetic or elective orthodontic care, periodontic care or general dental care.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthroscopy and open or closed reduction of dislocations.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

50. THERAPEUTIC TREATMENTS — OUTPATIENT

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician’s office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

51. TRANSFUSIONS/INFUSIONS

Benefits for transfusions/infusions include the following and must be for the treatment of a covered condition:

- Blood Transfusions.
- Infusions requiring medical supervision provided in a Physician’s office.

52. TRANSPLANTATION SERVICES
Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

All transplant services require Prior Authorization. We have specific guidelines regarding Benefits for transplant services. Contact Us at the telephone number on your ID card for information about these guidelines.

53. URGENT CARE CENTER SERVICES

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician’s office, Benefits are available as described under Physician’s Office Services - Sickness and Injury.

54. URINARY CATHETERS (INTERMITTENT AND INDWELLING)

Benefits for intermittent and indwelling urinary catheters include:

- Members who have permanent urinary incontinence or permanent urinary retention.
- Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that person within 3 months.
- Covered supplies with quantities:
  - Lubricant, individual sterile pack, each – 200 per month
  - Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each – 200 per month
  - Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each – 200 per month
  - Intermittent urinary catheter, with insertion supplies - 200 per month
  - Insertion tray with drainage bag with indwelling catheter, Foley-type, 2-way, latex with coating – 1 per month
  - Insertion tray with drainage bag with indwelling catheter, Foley-type, 2-way, all silicone – 1 per month
  - Insertion tray with drainage bag with indwelling catheter, Foley-type, 3-way, for continuous irrigation – 1 per month
  - Insertion tray with drainage bag but without catheter – 1 per month
  - Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each - 2 per month
  - Urinary leg bag; vinyl, with or without tube - 2 per month
  - Bedside drainage bottle with or without tubing, rigid or expandable - 1 every 3 months
  - Urinary leg bag; latex - 1 per month
55. VISION EXAMINATIONS

Vision examinations for individuals without eye disease or diagnosis beyond refraction, including refraction to detect vision impairment, received from a health care Provider in the Provider’s office.

- An annual eye exam for children 18 years old and under performed by an optometrist or ophthalmologist
- An eye exam every two years for adults over 18 years of age performed by an optometrist or ophthalmologist
- For children 18 years old and under, one pair of eyeglasses per calendar year:
  - Eyeglass Lenses — You have a choice in your eyeglass lenses; lenses include factory scratch coating at no additional cost. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:
    - Single vision
    - Bifocal
    - Trifocal (FT 25-28)
    - Progressive (for Members through age 18)
    - Contact lenses
  - Basic frames* are covered once every 12 months

NOTE: If you receive elective or non-elective contact lenses, then no benefits will be available for eyeglass lenses and frames until you satisfy the benefit frequency listed in the *Summary of Benefits*.

Please note that *Benefits* are not available for charges connected to the fitting of eyeglasses or contact lenses or the purchase of eyeglasses for adults over 18 years of age.

*Benefits* for eye examinations required for the diagnosis and treatment of a *Sickness* or *Injury* are provided under *Physician’s Office Services - Sickness and Injury*.
SECTION 2: EXCLUSIONS AND LIMITATIONS

HOW WE USE HEADINGS IN THIS SECTION

To help you find specific exclusions more easily, We use headings (for example A. Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

WE DO NOT PAY BENEFITS FOR EXCLUSIONS

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either or both of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: Covered Health Services or through a Rider to the Policy.

BENEFIT LIMITATIONS

When Benefits are limited within any of the Covered Health Service categories described in Section 1: Covered Health Services, those limits are stated in the corresponding Covered Health Service category in the Schedule of Benefits. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits under the heading Benefit Limits. Please review all limits carefully, as We will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when We say "this includes," it is not Our intent to limit the description to that specific list. When We do intend to limit a list of services or examples, We state specifically that the list "is limited to."

A. ALTERNATIVE TREATMENTS

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism. Clinical Hypnotherapy is covered if offered as part of a course of behavioral counseling/therapy by an accredited professional.
4. Massage therapy.
5. Rolfing.
6. Swim or pool therapy
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1: Covered Health Services.
B. AUTISM SPECTRUM DISORDER SERVICES

Exclusions listed directly below apply to services described under Autism Spectrum Disorder Services in Section 1: Covered Health Services.


2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.


4. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

5. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee. This exclusion does not apply for Autism Spectrum Disorder Services provided as the result of an Emergency detention, commitment or court order.

C. DENTAL

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services and Temporomandibular Joint Disorder Services in Section 1: Covered Health Services.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
Endodontics, periodontal surgery and restorative treatment are excluded except as related to trauma.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   • Extraction, restoration and replacement of teeth.
   • Medical or surgical treatments of dental conditions.
   • Services to improve dental clinical outcomes.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services and Temporomandibular Joint Disorder Services in Section 1: Covered Health Services.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services, Oral Surgery and Temporomandibular Joint Disorder Services in Section 1: Covered Health Services.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, for cosmetic surgery performed only to improve appearance.

D. DEVICES, APPLIANCES AND PROSTHETICS

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.

3. The following items are excluded, even if prescribed by a Physician:
   • Blood pressure cuff/monitor.
   • Enuresis alarm.
   • Non-wearable external defibrillator.
   • Trusses.
   • Ultrasonic nebulizers.

4. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.

5. Oral appliances for snoring.

6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

8. Wearable robotic exoskeleton systems.

E. EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or
Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Determination on whether services are Experimental, Investigational and Unproven Services are made by Our Medical Director in consultation with a specialty review panel. When We receive a request for an Experimental, Investigational, or Unproven Service, We will issue a Benefit decision within five working days. If We decide there is no coverage for the Experimental, Investigational, or Unproven treatment, procedure, or device for a Covered Person with a terminal condition or Sickness, We will include the following information in the non-coverage letter:

- A statement that includes the specific medical and scientific reasons for denying coverage.
- A notice of the Covered Person’s right to appeal.
- A description of the appeal process.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.

F. FOOT CARE

1. Routine foot care. Examples include the cutting or removal of corns and calluses hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.


7. Shoe orthotics.

8. Shoe inserts.


G. MATERNITY SERVICES

1. Elective abortions: elective abortions are to be excluded except when performed to save the life/health of the mother and in instances of rape or incest.

2. Home or intended out of hospital deliveries.

3. Amniocentesis or CVS (Chorionic Villi Sampling) performed exclusively for sex determination.
4. Birthing classes.

5. Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.

H. MEDICAL SUPPLIES AND EQUIPMENT

1. Non-prescribed medical supplies, which include but are not limited to:
   - Compression stockings and/or elastic stockings
   - Ace bandages
   - Gauze and dressings
   - Urinary catheters

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.
   - Ostomy supplies for which Benefits are provided as described under Ostomy Supplies Section 1: Covered Health Services.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1: Covered Health Services.

3. Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services, or any equipment required to be covered as a Preventive Service in Section 1: Covered Health Services.

I. MENTAL HEALTH

Exclusions listed directly below apply to services described under Mental Health Services in Section 1: Covered Health Services.


3. Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or
management according to prevailing national standards of clinical practices, as reasonably determined by the Mental Health/Substance Use Disorder Designee. This exclusion does not apply for Mental Health Services provided as the result of an Emergency detention, commitment or court order.

6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.


10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.

11. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   • Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   • Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   • Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
   • Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

**J. NUTRITION**

1. Individual and group nutritional counseling. This exclusion does not apply to any counseling required to be covered as a Preventive Service in Section 1: Covered Health Services, or any medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   • Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   • There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition
3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

**K. PERSONAL CARE, COMFORT OR CONVENIENCE**

1. Television.

2. Telephone.


4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps (except when required to be covered as a Preventive Service in Section 1: Covered Health Services).
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Electric Scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. PHYSICAL APPEARANCE

1. **Cosmetic Procedures.** See the definition in Section 7: Health Services Definitions. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1: Covered Health Services.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

6. Wigs regardless of the reason for the hair loss.

7. Botox (Botulinum toxin) is considered cosmetic and not Medically Necessary as a treatment of skin wrinkles or other cosmetic indications.

M. PROCEDURES AND TREATMENTS
1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder Services.

6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

7. Psychosurgery.

8. Gender reassignment operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.


11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer obstructive sleep apnea or temporomandibular joint disorder.


13. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

14. Breast reduction surgery except as coverage is required by the Women’s Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.

N. PROVIDERS

1. Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.

2. Services performed by a Provider with your same legal residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other Provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or
representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

O. REPRODUCTION

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

4. The reversal of voluntary sterilization and related procedures.

5. In vitro fertilization regardless of the reason for treatment.

P. SERVICES PROVIDED UNDER ANOTHER PLAN

1. Health services for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

Q. SUBSTANCE USE DISORDERS


2. Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.

3. Methadone treatment as maintenance, L.A.A.M. (1-Acetyl-Methadol), Cyclazocine, or their equivalents.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
6. Treatment and services received at halfway house.

7. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   • Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   • Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   • Not consistent with the Mental Health/Substance Use Disorder Designee’s level of care guidelines or best practices as modified from time to time.
   • Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient’s Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

R. TRANSPLANTS

1. Health services for organ and tissue transplants and all related expenses, except those described under Transplantation Services in Section 1: Covered Health Services.

2. Services and supplies in connection with covered transplants unless prior authorized by Us.

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

4. Any experimental or investigational transplant, or any other transplant-like technology not listed in the Member Certificate. Any resulting complications from these, and any services and supplies related to such experimental or investigational transplantation or complications, including, but not limited to: high dose chemotherapy, radiation therapy or immunosuppressive drugs

5. Health services for transplants involving permanent mechanical, artificial or animal organs.

S. TRAVEL

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at Our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1: Covered Health Services.
T. TYPES OF CARE

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care or therapy.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1: Covered Health Services.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. VISION AND HEARING

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

2. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

3. Eye exercise or vision therapy.

4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

5. Bone anchored hearing aids except when either of the following applies:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

V. ALL OTHER EXCLUSIONS

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 7: Health Services Definitions.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
• Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.

• Related to judicial or administrative proceedings or orders.

• Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.

• Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a non-Network Provider waives Copayments, Coinsurance and/or any Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.


10. Dry needling, prolotherapy.

11. Coma Stimulation programs.

12. Court ordered care, unless medically necessary and otherwise covered under the certificate.

13. Services and supplies rendered outside the scope of the provider's license.

14. Foreign language and sign language services.

15. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services We would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
COMMON GROUND HEALTHCARE COOPERATIVE
OUTPATIENT PRESCRIPTION DRUG

OUTPATIENT PRESCRIPTION DRUG INTRODUCTION

The Plan makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Pharmaceutical Products are assigned to various tiers. The Plan makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product’s acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six (6) times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, review the current CGHC Formulary at www.CommonGroundHealthcare.org or the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements at www.CommonGroundHealthcare.org or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.CommonGroundHealthcare.org or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.
Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

When considering a Prescription Drug Product for tier placement, We review clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.commongroundhealthcare.org or call the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card for the most up-to-date tier status.

IDENTIFICATION CARD (ID CARD) — NETWORK PHARMACY

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by Us during regular business hours.

If you don’t show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from Us. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

DESIGNATED PHARMACIES

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, We may direct you to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product. If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, We may direct you to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

REBATES AND OTHER PAYMENTS
We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Deductible, Copayments and/or Coinsurance.
SECTION 3: COVERED PRESCRIPTION BENEFITS

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a Non-Network Pharmacy and are subject to Deductibles, Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Deductible, Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

SPECIALTY PRESCRIPTION DRUG PRODUCTS

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, We may direct you to a Designated Pharmacy with whom We have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will incur the difference in cost between the Prescription Drug Product you purchase and the cost from the designated Pharmacy Provider.

Please see Section 8: Prescription Drug Definitions for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

PRESCRIPTION DRUGS FROM A RETAIL NETWORK PHARMACY

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

PRESCRIPTION DRUGS FROM A RETAIL NON-NETWORK PHARMACY

Benefits are provided for Prescription Drug Products dispensed by a retail Non-Network Pharmacy.

PRESCRIPTION DRUG PRODUCTS FROM A MAIL ORDER NETWORK PHARMACY

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Please access www.CommonGroundHealthcare.org call the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.
SECTION 4: PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

Exclusions from coverage listed in the Certificate apply also to this section. In addition, the exclusions listed below apply.

1. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.


3. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by Us to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products that are prescribed by a Physician for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for the Investigational new drug.

4. Prescription Drug Products furnished by the local, state or Federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.

5. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers’ compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.

6. Any product dispensed for the purpose of appetite suppression or weight loss.

7. Durable Medical Equipment covered under the Medical Benefits for Covered Health Services.

8. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

9. Unit dose packaging of Prescription Drug Products.

10. Medications used for cosmetic purposes.

11. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that We determine do not meet the definition of a Covered Health Service.

12. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed will be allowed as a one-time exception.

13. Prescription Drug Products when prescribed to treat infertility.

14. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill.
15. Drugs available over-the-counter that do not require a Prescription Order or Refill by Federal or state law before being dispensed, unless We have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that We have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

16. New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by Our Pharmacy & Therapeutics Management Committee.

17. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

18. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

19. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Prescription Drug Products rendered in a Physician's office or other outpatient setting that can be safely and effectively delivered in the home setting, either orally or by self-injection.
SECTION 5: COORDINATION OF BENEFITS

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

This section describes how Benefits under the Policy will be coordinated with those of any other Plan that provides Benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating Benefits.

WHEN COORDINATION OF BENEFITS APPLIES

This Coordination of Benefits (COB) provision applies when a person has health insurance coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for Benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay Benefits in accordance with its Policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the Benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

DEFINITIONS

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides Benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or any other Federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; Benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other Federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care Benefits to which the COB provision applies and which may be reduced because of the Benefits of other plans. Any other part of the contract providing health care Benefits is separate from This Plan. A contract may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and
may reduce the Benefits it pays so that all Plan Benefits do not exceed 100% (TBD) of the total Allowable Expense.

D. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides Benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

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

3. If a person is covered by two 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.

4. If a person is covered by one Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its Benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care 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 excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
A. The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the Benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits and provides that this supplementary coverage shall be in excess of 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.

C. 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.

D. Each Plan determines its order of Benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, Subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of Benefits as follows:

   a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This shall not apply with respect to any Plan year during which Benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the Dependent child’s health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of Benefits.
(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph a) above shall determine the order of Benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of Benefits for the child are as follows:

   (a) The Plan covering the Custodial Parent.

   (b) The Plan covering the Custodial Parent's spouse.

   (c) The Plan covering the non-Custodial Parent.

   (d) The Plan covering the non-Custodial Parent's spouse.

   c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of Benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of Benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other Federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the Primary Plan, and the COBRA or state or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of Benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of Benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total Benefits paid or provided by all Plans for the claim do not
exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-covered services because the person did not follow all rules of that Plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the Federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health insurance coverage and services are needed to apply these COB rules and to determine Benefits payable under This Plan and other Plans. We may get the facts We need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Plan and other Plans covering the person claiming Benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Us any facts We need to apply those rules and determine Benefits payable. If you do not provide Us the information We need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

PAYMENTS MADE

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

RIGHT OF RECOVERY
If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

WHEN MEDICARE IS SECONDARY

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced Benefits. In no event will the combined Benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.
SECTION 6: GENERAL LEGAL PROVISIONS

YOUR RELATIONSHIP WITH US

In order to make choices about your health care coverage and treatment, We believe that it is important for you to understand how We interact with your Benefit Plan and how it may affect you. We help finance or administer the Benefit Plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether your Benefit Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this Certificate.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in Our operations and in Our research. We will use de-identified data for commercial purposes including research.

Please refer to Our Notice of Privacy Practices for details.

OUR RELATIONSHIP WITH PROVIDERS

We do not provide health care services or supplies, nor do We practice medicine. Instead, We arrange for health care Providers to participate in a Network and We pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Our employees nor do We have any other relationship with Network Providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any Provider is that of provider and patient.

- You are responsible for choosing your own Provider.
- You are responsible for paying, directly to your Provider, any amount identified as a Member responsibility, including 
  Copayments, Coinsurance, any Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network Providers you choose and Providers to whom you have been referred.
- You must decide with your Provider what care you should receive.
• Your Provider is solely responsible for the quality of the services provided to you.

NOTICE

We provide written notice regarding administration of the Policy to You as the an authorized representative of the Policy and that notice is deemed notice to all affected Subscribers and their Enrolled Dependents.

STATEMENTS BY SUBSCRIBER

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, We will not use any statement made by a Subscriber to void the Policy after it has been in force for a period of two years.

INCENTIVES TO PROVIDERS

We pay Network Providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

We use various payment methods to pay specific Network Providers. From time to time, the payment method may change. If you have questions about whether your Network Provider’s contract with Us includes any financial incentives, We encourage you to discuss those questions with your Provider. You may also contact Us at the telephone number on your ID card. We can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

INCENTIVES TO YOU

Sometimes We may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but We recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact Us if you have any questions.

REBATES AND OTHER PAYMENTS

We may receive rebates for certain drugs that are administered to you in your home or in a Physician’s office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Deductible. We do not pass these rebates on to you, nor are they applied to any Deductible or taken into account in determining your Copayments or Coinsurance.

INTERPRETATION OF BENEFITS

We have the sole and exclusive discretion to do all of the following:

• Interpret Benefits under the Policy.

• Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this Certificate, the Schedule of Benefits and any Riders and/or Amendments.
• Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case shall not in any way be deemed to require Us to do so in other similar cases.

ADMINISTRATIVE SERVICES

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give you prior notice of any such change, nor are We required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

AMENDMENTS TO THE POLICY

To the extent permitted by law, We reserve the right, in Our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

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

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of Our officers. All of the following conditions apply:

• Amendments to the Policy are effective 31 days after We send written notice to the Subscriber.
• Amendments that result in a reduction of Benefits will be effective upon 60 days prior written notice.
• Riders are effective on the date We specify.
• No agent has the authority to change the Policy or to waive any of its provisions.
• No one has authority to make any oral changes or Amendments to the Policy.

INFORMATION AND RECORDS

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how We may use or disclose your information is found in Our Notice of Privacy Practices.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish Us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber’s application. We agree that such information and records will be considered confidential.
We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as We are required to do by law or regulation. During and after the term of the Policy, We and Our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to Our Notice of Privacy Practices.

For complete listings of your medical records or billing statements We recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Us, We also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, We will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as We have.

EXAMINATION OF COVERED PERSONS

In the event of a question or dispute regarding your right to Benefits, We may require that a Network Physician of Our choice examine you at Our expense.

WORKERS’ COMPENSATION NOT AFFECTED

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers’ compensation insurance.

MEDICARE ELIGIBILITY

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if We are the secondary payer as described in Section 9: Coordination of Benefits, We will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that Plan that require you to seek services from that Plan's participating providers. When We are the secondary payer, We will pay any Benefits available to you under the Policy as if you had followed all rules of the Medicare Advantage Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, We shall be subrogated to and
shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits We provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, We shall also have an independent 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.
- 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 or 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:
  - 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.
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.

- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health Benefits or the instigation of legal action against you.

- That We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- That no court costs or attorneys' fees may be deducted from Our recovery without Our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and We are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal Injury claim.

- That after 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 judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

- That Benefits paid by Us may also be considered to be Benefits advanced.
• That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

• That you or an authorized agent, such as your attorney, must hold any funds due and owing Us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health Benefits or the instigation of legal action against you.

• That We may set off from any future Benefits otherwise provided by Us the value of Benefits paid or advanced under this section to the extent not recovered by Us.

• 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 you will assign to Us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits We provided, plus reasonable costs of collection.

• That Our rights will be considered as the first priority claim against Third Parties, including tortfeasors from 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 rights under these subrogation provisions, including filing suit in your name, which does not obligate Us in any way to pay you 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.

• That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.

• That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

REFUND OF OVERPAYMENTS

If We pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Us if any of the following apply:

• All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

• All or some of the payment We made exceeded the Benefits under the Policy.

• All or some of the payment was made in error.

The refund equals the amount We paid in excess of the amount We should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help Us get the refund when requested.
If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, We may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

LIMITATION OF ACTION

We encourage You to complete all the steps in the appeal process described in Appeal/Grievances Section as an effective way of resolving disputes on a timely basis. After completing that process, if you want to bring a legal action against Us you must do so within three years of the date We notified you of Our final decision on your appeal or you lose any rights to bring such an action against Us.

ENTIRE POLICY

The Policy issued to the Subscriber, including this Certificate, the Schedule of Benefits, and any Riders and/or Amendments, constitutes the entire Policy.
**SECTION 7: HEALTH SERVICES DEFINITIONS**

**Alternate Facility** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- *Emergency Health Services*.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide *Mental Health Services* or *Substance Use Disorder Services* on an outpatient or inpatient basis.

**Amendment** - any attached written description of additional or alternative provisions to the *Policy*. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of *Eligible Expenses* you must pay for *Covered Health Services* per year before We will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

**Benefits** - your right to payment for *Covered Health Services* that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Certificate, the Schedule of Benefits and any attached Riders and/or Amendments.

**Benefit Period** – the length of time that We will pay Benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before the length of time, then the Benefit Period also ends.

**Certificate** – the document providing a summary of the terms of your Benefits. It is attached to, and is a part of, the Policy.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Copayment** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for *Covered Health Services*, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.
Covered Health Service(s) - those health services, including services, supplies, or Pharmaceuticals:

- Medically Necessary.
- Described as a Covered Health Service in this Certificate under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.
- Provided for the purpose of preventing, diagnoseing or treating a Sickness, Injury, Mental Illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting Our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.COMMONGROUNDHEALTHCARE.ORG or by calling the Member Services Department at the telephone number on your ID card.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before We will begin paying for Benefits. The amount that is applied to the Deductible is calculated on the basis of
Eligible Expenses. The Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan is subject to payment of a Deductible and for details about how the Deductible applies.

Dependent - the Subscriber’s legal spouse or an unmarried Dependent child of the Subscriber or the Subscriber’s spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber’s spouse.
- A child of an Enrolled Dependent child (until the Enrolled Dependent who is the parent turns 18).

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried Dependent child under 26 years of age who is not eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent’s premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the Subscriber’s Plan.

- A Dependent includes an unmarried Dependent child of any age who is or becomes disabled and Dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month in which the child turns 26 years of age.

The Subscriber must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

A Dependent also includes an adult child who meets the following requirements:

- A full-time Student, regardless of age.

- Not married or eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent’s premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the Subscriber’s Plan.

- Was under age 27 when called to Federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the Dependent was attending on a full-time basis, an institution of higher education. If the adult Dependent ceases to be a full-time Student due to Medically Necessary leave of absence, then coverage must be continued in accordance with the
existing law for continued coverage of students on medical leave, and age is not a factor that would affect when such continued coverage would end.

**Designated Facility** - a facility that has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Network Benefits** - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that We have identified as Designated Network Providers. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Physician** - a Physician that We've identified through Our designation programs as a designated Provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Durable Medical Equipment** - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Effective Date** – the date that a Subscriber’s coverage begins under this Certificate. A Dependent’s coverage also begins on the Subscriber’s Effective Date, unless otherwise indicated in this Certificate.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by Us as stated below and as detailed in the Schedule of Benefits.

Eligible Expenses are determined solely in accordance with Our reimbursement Policy guidelines. We develop Our reimbursement Policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

**Eligible Person** - a person who meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.
**Emergency** - a serious medical condition or symptom resulting from *Injury, Sickness* or *Mental Illness* including severe pain which would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organ or parts.

**Emergency Health Services** - health care services and supplies necessary for the treatment of an *Emergency*.

**Enrolled Dependent** - a *Dependent* who is properly enrolled under the *Policy*.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

**Exceptions:**

- Clinical trials for which *Benefits* are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening *Sickness* or Condition. If you have a life-threatening *Sickness* or condition (one that is likely to cause death within one year of the request for treatment) We may, in Our discretion, consider an otherwise Experimental or Investigational Service to be a *Covered Health Service* for that *Sickness* or condition. Prior to such a consideration, We must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that *Sickness* or condition.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

**Habilitative Services** - health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.
Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.

- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic Manipulative Treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Allowed Amount – The maximum amount of the billed charge from a participating provider or non-participating provider is determined by the Plan based upon what it deems payable for covered services for a Member.

For participating providers, the Maximum Allowed Amount is the agreed upon reimbursement rate (fee schedule, discounted amount, DRG, other payment methodology) that the provider and Plan have agreed upon.

For non-participating providers, the Maximum Allowed Amount is either:

- An amount the Plan and provider negotiate;

- An amount obtained via a Network utilized by Plan that has an agreement with the non-participating provider;
- A function of an amount set by an independent third party which provides usual and customary charges for the services the Member received and adjusted by the Plan.

**Maximum Policy Benefit** – the maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan.

**Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by Us or Our designee, within Our sole discretion.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

**Generally Accepted Standards of Medical Practice** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Our sole discretion.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting Our determinations regarding specific services. These clinical policies (as developed by Us and revised from time to time), are available to Covered Persons on www.commongroundhealthcare.org or by calling the Member Services Department at the telephone number on your ID card.

**Medicare** - Parts A, B, C and D 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.

**Member** – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Premium payment. Members are sometimes called “you” or “your” in this Certificate.

**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by Us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.
**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with Us or with Our affiliate to participate in Our Network.

A provider may enter into an agreement to provide only certain *Covered Health Services*, but not all *Covered Health Services*, or to be a Network Provider for only some of Our products. In this case, the provider will be a Network Provider for the *Covered Health Services* and products included in the participation agreement, and a non-Network Provider for other *Covered Health Services* and products. The participation status of providers will change from time to time.

**Network Benefits** - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for *Covered Health Services* provided by Network Providers. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan offers Network Benefits and for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for *Covered Health Services* provided by non-Network Providers. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

**Non-Network Provider/Facility** – an out-of-network provider/facility is one which has not contracted with CGHC for reimbursement at a negotiated rate. CGHC offers coverage for out-of-network providers, but your patient responsibility would be higher than it would be if you were seeing an in-network provider or using an in-network facility.

**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the Schedule of Benefits to determine whether or not your Benefit Plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Pharmaceutical Product(s)** - U.S. Food and Drug Administration (FDA)-approved prescription Pharmaceutical Products administered in connection with a *Covered Health Service* by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Pharmaceutical Product List** - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at [WWW.COMMONGROUNDHEALTHCARE.ORG](http://WWW.COMMONGROUNDHEALTHCARE.ORG) or by calling their Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

**Plan (or We, Us, Our)** – Common Ground Healthcare Cooperative which provides Benefits to Members for the Covered Services described in this Certificate.
**Pharmaceutical Product List Management Committee** - the committee that We designate for, among other responsibilities, classifying *Pharmaceutical Products* into specific tiers.

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, psychologist, chiropractor, optometrist, clinical social worker, marriage and family therapist, nurse practitioner, professional counselor or other provider who acts within the scope of his or her license will be considered on the same basis as a *Physician*. The fact that We describe a provider as a *Physician* does not mean that *Benefits* for services from that provider are available to you under the *Policy*.

**Policy** - the entire agreement issued to you that includes all of the following:

- This *Certificate*.
- The *Schedule of Benefits*.
- Your application.
- *Amendments*.
- *Notices*.

**Policy Charge** - the sum of the Premiums for you and your *Enrolled Dependent* s enrolled under the *Policy*.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with *Pregnancy*.

**Premium** - the periodic fee required for each *Subscriber* and each *Enrolled Dependent*, in accordance with the terms of the *Policy*.

**Prescription Drug** – a drug available only by prescription; a drug that can be dispensed only upon presentation of a legally valid prescription.

**Primary Physician** - a *Physician* who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine or geriatrics.

**Prior Authorization** – the advance, written authorization, with appropriate documentation for specific medical services or treatment. Services requiring *Prior Authorization* are specified in Article V of the Certificate and in the *Schedule of Benefits*. Failure to obtain *Prior Authorization* when required will result in the *Member* receiving a lesser benefit.

**Private Duty Nursing** - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a *Home Health Agency* on a per visit basis for a specific purpose.
• The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Rehabilitative - health care services that help You keep, get back, or improve skills and functioning for daily living that have been lost or impaired because You were sick, hurt or disabled.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

• It is established and operated in accordance with applicable state law for residential treatment programs.

• It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.

• It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.

• It provides at least the following basic services in a 24-hour per day, structured milieu:
  o Room and board.
  o Evaluation and diagnosis.
  o Counseling.
  o Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Schedule of Benefits – a list of the benefits, amount of coverage provided in a health insurance policy.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area We serve and that has been approved by the appropriate regulatory agency. Contact Us to determine the exact geographic area We serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine or geriatrics.
**Subscriber** - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Individual.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

**Total Disability or Totally Disabled** - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

**Transitional Care** - Mental Health Services and Substance Use Disorder Services that are provided in a less restrictive manner than inpatient Hospital services but more intensive than outpatient services. Services are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide Members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Transitional Treatment** – We cover transitional treatment services provided by qualified providers for each day for which clinical records substantiate that the treatment is Medically Necessary, medically appropriate, and cost-effective.

Transitional treatment is Medically Necessary, medically appropriate, and cost-effective only if the required intensity and frequency of treatment cannot be provided safely and effectively through outpatient treatment services.

Transitional treatment refers to mental health and alcohol or other substance abuse treatment that is not inpatient but is more intensive than outpatient treatment. Examples of types of transitional treatment include:

- Day treatment or evening treatment programs.
- Partial hospitalization.
- Intensive Outpatient Treatment.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
• Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

• Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.CommonGroundHealthcare.org.

Please note:

• If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

• We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service. Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
  • It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  • The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  • At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  • The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but Unproven Services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.
SECTION 8: PRESCRIPTION DRUG DEFINITIONS

**Ancillary Charge** - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or MAC list price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

**Brand-name** - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by Us.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

**Generic** - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that We identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by Us.

**Maximum Allowable Cost (MAC) List** - a list of Generic Prescription Drug Products that will be covered at a price level that We establish. This list is subject to Our periodic review and modification.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with Us or an organization contracting on Our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by Us as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by Our PDL Management Committee.
- December 31st of the following calendar year.
**Out-of-Pocket Maximum** - the maximum amount you are required to pay for Medical and Prescription Drugs in a single year. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.

**Prescription Drug Cost** - the rate We have agreed to pay Our *Network* Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a *Network* Pharmacy.

**Prescription Drug List** - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration* (FDA). This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [WWW.COMMONGROUNDHEALTHCARE.ORG](http://WWW.COMMONGROUNDHEALTHCARE.ORG) or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

**Prescription Drug List (PDL) Management Committee** - the committee that We designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, product or device that has been approved by the *U.S. Food and Drug Administration* (FDA) and that can, under Federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of *Benefits* under the *Policy*, this definition includes:

- Inhalers (with spacers);
- Insulin;
- Immunizations administered in a pharmacy;
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose monitors (one per year).

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [WWW.COMMONGROUNDHEALTHCARE.ORG](http://WWW.COMMONGROUNDHEALTHCARE.ORG) or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

**Therapeutic Class** - a group or category of Prescription Drug Products with similar uses and/or actions.

**Therapeutically Equivalent** - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.
**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
APPEALS/GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW REQUESTS

The following terms apply to this section:

**Complaint** - Your verbal expression of dissatisfaction with Us or any Network Provider.

**Grievance** - A grievance is any written complaint or dispute (other than an organization determination) expressing dissatisfaction with any aspect of operations, activities or any Network provider including written complaints regarding claims practices, the provision of services, a determination to reform or rescind a policy or a determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.

**Appeal** - An appeal is any grievance regarding the denial, reduction or termination of a benefit (in whole or in part).

COMPLAINTS

There may instances when you have a complaint. If that happens, please contact the Member Services Department shown on your ID card. A Member Services representative will try to resolve your complaint informally to the extent possible. If you are not satisfied with the resolution of your complaint, then you may file an Appeal or Grievance.

APPEAL/GRIEVANCE PROCESS

You, or your authorized representative, may file a written expression of dissatisfaction (an Appeal/Grievance) with Us. The Appeal/Grievance may involve our administration or claim practices (including a denial of a claim you think should be paid by Us), adverse determinations regarding the levels of benefits available or the provision of services provided to you. Expedited Appeals/Grievances, as described below, do not require that your Appeal/Grievance first be submitted in writing to Us. If necessary, the Appeal/Grievance will be evaluated by the Member Appeal & Grievance Committee and a response will be made to you within 30 calendar days. The Appeal/Grievance should be mailed to:

Common Ground Healthcare Cooperative - Member Services Department
ATTN: Member Appeals & Grievances
P.O. Box 1630
Brookfield, WI 53008-1630

We will acknowledge receipt of the Appeal/Grievance within five business days of receipt and the Appeal/Grievance will be added to the agenda of the next scheduled Member Appeal & Grievance Committee meeting. No fewer than seven (7) calendar days prior to the meeting, You will be notified of the date and time in case You would like to present your Appeal/Grievance in person, via teleconference and or video conference. We will provide you with any new or additional evidence considered, relied upon, or generated by Us in connection with the Appeal/Grievance. We will send you a written determination of the
Appeal/Grievance within 30 calendar days of receipt of the Appeal/Grievance. If special circumstances require a longer review period, We may take an additional 15 calendar days to make a decision. If We need the extra days, We will notify you of the reason why and when a decision may be expected.

EXPEDITED APPEAL/GRIEVANCE REQUEST

You may make a written or oral request for an Expedited Appeal/Grievance if:

(1) An adverse benefit determination that involves a medical condition for which the timeframe for completion of a standard Independent External Review would seriously jeopardize your life or health, or, would jeopardize your ability to regain maximum function; and

(2) If the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the you have received services but has not been discharged from the facility and you or your designee have filed a request for an Expedited Independent External Review.

INDEPENDENT EXTERNAL REVIEW

Independent External Review is available to you after you have exhausted the Internal Appeal/Grievance process (outlined above) or when federal law allows you to bypass the internal Appeal/Grievance process.

Qualifications for Independent External Review

In order to qualify for Independent External Review process, the following criteria must be met:

(1) The situation or issue must involve an adverse benefit coverage determination based on either:
   (a) Medical judgment (for example: medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or experimental and investigational treatments).
   (b) A denial of a request for out-of-network services when you believe that the clinical expertise of the out-of-plan Out-of-Network provider is medically necessary (but only if the treatment or service would otherwise be a covered benefit under your plan).
   (c) Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(2) Exhaustion of Appeal/Grievance Process. In most cases, you must have completed the Appeal/Grievance process prior to requesting an Independent External Review.

Exceptions to this circumstance are:
   a) Both We and you agree that the matter may proceed directly to Independent External Review; or
   b) You need immediate medical care or services. If this is the case, you may submit an Urgent Independent External Review Request (see below) if you believe that the time period for resolving an Appeal/Grievance would cause a delay that could jeopardize your life or health.
c) If We fail to adhere to all of the requirements of the Appeal/Grievance process, then You are deemed to have exhausted the internal claims and appeals process and can proceed to independent external review unless such failure is de minimus and:

- non-prejudicial to You
- attributable to good cause or matters beyond Our control
- in the context of an ongoing, good faith exchange of information between the You and Us; and
- not reflective of a pattern or practice of non-compliance by Us.

**Decisions not subject to Independent External Review**

You may not request an Independent External Review if:

1. The requested treatment is not a Covered Service under this Certificate;
2. The decision involves contractual or legal interpretation without any use of medical judgment;
3. For administration issues such as the application of amounts to your deductible.

**Request an Independent External Review**

To request an Independent External Review, you must submit a request within four months after the date you receive a notice that we denied your Appeal/Grievance. If there is no corresponding date four months after the date you receive a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date you receive the notice is October 30, because there is no February 30, the request must be filed by March 1.

The request for Independent External Review must be made in writing and sent to:

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HHS Federal Review Request
MAXIMUS Federal Services
3750 Monroe Avenue
Suite 705,
Pittsford, NY 14534
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You may also request external review by faxing your request to 1-888-866-6190. For cases requiring expedited review, your request may be made by phone by calling 1-888-866-6205.

The request should contain the following:

- Your name, address, and phone number.
- The reason you disagree with Our decision, including any documents that support your position.
- A statement authorizing your representative to pursue Independent External Review on your behalf if you choose to use one.

**Review by Independent Review Organization.**
The assigned IRO will review all the information and documents it timely receives. It will review Our decision independent of any decision or conclusions reached by Us as part of its internal Appeal/Grievance process.

You may, but are not required to, submit additional information in writing to the IRO. The IRO is required to consider any information or materials provided within ten (10) business days after you receive the initial notice from the IRO that your request for Independent External Review has been accepted. The IRO may, but is not required to, accept and consider additional information submitted after ten (10) business days. The IRO will forward any additional information you submit to Us.

The IRO will forward to Us any additional information submitted by You. If, on the basis of any additional information you submit, We reconsider your case and decide that the treatment should be covered, the Independent External Review is terminated. An Independent External Review does not include appearances by you or your authorized representative, any person representing Us, or any witness on behalf of either you or Us.

The IRO will provide written notice of its final decision to you and to Us within 45 days after the IRO receives the request for Independent External Review. The written decision will include a general description of the reason for the request including information necessary to identify the claim, the date the IRO received the assignment to conduct the Independent External Review and the date of the IRO’s decision, references to the evidence or documents the IRO considered in reaching its decision, and a discussion of the principal reason for its decision.

If the IRO provides written notice to Us that it is reversing the final internal adverse benefit determination, We will immediately provide coverage or payment for the requested item or service.

**Expeditied Independent External Review.**

You may make a written or oral request for an Expedited Independent External Review if:

1. An adverse benefit determination that involves a medical condition for which the timeframe for completion of a standard Independent External Review would seriously jeopardize your life or health, or, would jeopardize your ability to regain maximum function; and

2. If the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the You have received services but has not been discharged from the facility and the You or your designee have filed a request for an Expedited Independent External Review. The Expedited Independent External Review examiner will provide a notice of his/her decision as expeditiously as the medical circumstances require, but in no event longer than seventy-two (72) hours after the request for an Expedited Independent External Review. If You are in an urgent care situation and are also in an ongoing course of treatment for that condition, a decision will be provided within twenty-four (24) hours of receipt and acknowledgement that your case meets the criteria for Expedited Independent External Review. Notice of the decision may be provided orally but will also be provided in writing within forty-eight (48) hours.

Decisions of the IRO, either through regular or expedited review, are final unless the decision is regarding rescission.
OFFICE OF THE COMMISSIONER OF INSURANCE

You can use the Appeal/Grievance process described above to address any concerns or complaints you may have. You may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call (800)236-8517 (outside of Madison) or (608)266-0103 in Madison or email them at complaints@ociwi.state.us and request a complaint form.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide a revised notice by direct mail to you reflecting that change within 60 days of the change and we will otherwise post the revised notice on our website www.COMMONGROUNDHEALTHCARE.ORG. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

*For purposes of this Notice of Privacy Practices, "We" or "Us" refer to the health plans that are affiliated with Common Ground Healthcare Cooperative.

HOW WE USE OR DISCLOSE INFORMATION

We use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate Our business. For example, We may use or disclose your health information:

- **For Payment** of premiums due Us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other Benefits you may have. For example, We may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, We may disclose information to your Physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage Our business activities related to providing and managing your health care coverage. For example, We might talk to your Physician to suggest a disease management or wellness program that could help improve your health or We may analyze data to determine how We can improve Our services.

- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law as of February 17, 2010.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health Plan, We may share summary health information and enrollment and disenrollment information with the Plan sponsor. In addition, We may share other health information with the Plan sponsor for Plan administration if the Plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.

- **For Reminders.** We may use or disclose health information to send you reminders about your Benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an Emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, We will use Our best judgment to decide if the disclosure is in your best interests.

- **For Public Health Activities** such as reporting or preventing disease outbreaks.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
• **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

• **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

• **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an Emergency or natural disaster.

• **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

• **For Workers’ Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

• **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

• **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

• **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

• **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• **To Business Associates** that perform functions on Our behalf or provide Us with services if the information is necessary for such functions or services. Our business associates are required, under contract with Us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in Our contract. Our business associates are also will be directly subject to Federal privacy laws.

• **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your Plan through which you receive coverage.

Except for uses and disclosures described and limited as set forth in this notice, We will use and disclose your health information only with a written authorization from you. Once you give Us authorization to release your health information, We cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at any time in writing, except if We have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.
WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on Dependent access that authorize your dependents to request certain restrictions. Please note that while We will try to honor your request and will permit requests consistent with Our policies, We are not required to agree to any restriction.

- **You have the right to request** that a provider not send health information to Us in certain circumstances if the health information concerns a health care item or service for which you have paid the provider out-of-pocket in full.

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, We may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If We deny your request, you have the right to have the denial reviewed. If We maintain an electronic health record containing your health information, you have the right to request that We send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

- **You have the right to ask to amend** information We maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested Amendment. Mail your request to the address listed below. If We deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by Us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which Federal law does not require Us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at Our website, [WWW.COMMONGROUNDHEALTHCARE.ORG](http://WWW.COMMONGROUNDHEALTHCARE.ORG).

EXERCISING YOUR RIGHTS
• **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on the back of your ID card or you may contact the Common Ground Healthcare Cooperative Member Services Department at 1-877-514-CGHC (2442).

• **Submitting a Written Request.** Mail to Us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for Amendments to your record, at the following address:

  Common Ground Healthcare Cooperative  
  Member Services Department  
  120 Bishop's Way, Suite 150  
  Brookfield, WI 53005

• **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with Us at the address listed above.

• **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.
**WOMEN’S HEALTH AND CANCER RIGHTS ACT NOTICE**

The Women’s Health and Cancer Rights Act of 1998 requires this Notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving Benefits under their Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

*Our current health plans already provide coverage for these services.*

Benefits are elective to the patient, and would be provided in consultation between the patient and attending physician.

Deductibles, coinsurance and co-payment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

If you have any questions or concerns, please contact Member Services at 1-877-514-CGHC (2442).

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**NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan.

**STATEMENT OF RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT**

Under Federal law known as the “Newborns’ and Mothers’ Health Protection Act of 1996” (Newborns’ Act), group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under Federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a Plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).
However, to use certain providers or facilities, or to reduce Your Out of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan administrator.