COMMON GROUND HEALTHCARE COOPERATIVE

GROUP CERTIFICATE OF COVERAGE, AMENDMENTS AND NOTICES

Certificate ID Number: CGHC.1000

Effective Date: January 1, 2018

Offered and Underwritten by

Common Ground Healthcare Cooperative

Common Ground Healthcare Cooperative

120 Bishop's Way, Suite 150
Brookfield, WI 53005-6271

GUARANTEED RENEWABILITY

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

THIS POLICY CONTAINS NETWORK BENEFITS

To receive the highest level of covered Benefits at the lowest out-of-pocket cost, Covered Health Services must be provided by an In-Network Provider. Participating Network 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. You may be billed by your Participating Provider(s) for any non-Covered Health Services you receive or when you have not acted in accordance with this Certificate.

LIMITED BENEFITS WILL BE PAID WHEN NON-NETWORK PROVIDERS ARE USED

Coverage of Covered Health Services provided by Non-Network Provider is limited to the amount We determine in accordance with the Maximum Allowed Amount as defined in Section 7 of this Certificate. You may be responsible for paying any difference between the amount the Non-Network Provider charges you and the Maximum Allowed Amount We will pay.

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 at 877.514.2442 or by going to **WWW.COMMONGROUNDHEALTHCARE.ORG.**

THIS POLICY CONTAINS A PRIOR AUTHORIZATION REQUIREMENT

Benefits may be reduced or excluded if you fail to pre-authorize certain treatment and procedures. Read the Prior Authorization section carefully. A Prior Authorization is not a guarantee of payment of benefits.

THIS POLICY DOES NOT CONTAIN PEDIATRIC DENTAL SERVICES

This Policy does not include pediatric dental services that are required under the federal Patient Protection and Affordable Care Act. You may purchase a stand-alone dental care plans through the Marketplace.

CERTIFICATE OF COVERAGE

TABLE OF CONTENTS

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 the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy.

In addition to this Certificate the Policy includes:

- The Master Group Policy
- The Schedule of Benefits
- Amendments and Riders (if applicable)
- Notices
- Your Application

You can review the Policy at the office of the Enrolling Group or 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 Amendments and/or Notices that may change certain provisions of this Certificate. When that happens We will send new Certificate, Amendment or Notice 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 12:00 midnight on your effective date and end at 11:59 pm in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to When Coverage Ends provision of the Policy.

We are delivering the Policy in the State of Wisconsin. If the Policy is issued to an Enrolling Group and is part of an employee welfare benefit plan as defined by ERISA, the Policy shall be governed by ERISA except to the extent that the laws of the State of Wisconsin govern the Policy.

INTRODUCTION TO YOUR CERTIFICATE

We are pleased to provide you with this Certificate. This Certificate and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

HOW TO USE THIS DOCUMENT

We encourage you to read your Certificate and any attached 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 by the Enrolling Group or entity, 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: *Definitions*. You can refer to Section 7: *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: *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 our Member Services Department at 877.514.2442. This number is also listed on your ID card. Helping our Covered Persons understand their Benefits is an important part of our mission as a non-profit Cooperative, and it will be our pleasure to assist you when you call.

YOUR RESPONSIBILITIES

BE ENROLLED AND PAY REQUIRED CONTRIBUTIONS

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in When Coverage Begins. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as an Eligible Person or his or her Dependent as those terms are defined in Section 7: *Definitions*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

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 Network health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in our 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 Certificate's exclusions.

SHOW YOUR IDENTIFICATION CARD

You should show your identification (ID) card every time you request healthcare services. Showing your ID card will help ensure timely and accurate submission of Your claims

PROVIDE US WITH WRITTEN NOTICE OF LOSS/YOUR CLAIMS

Generally, your Provider will send us claims for treatment you receive. Technically, this is your responsibility. This is important to understand because we must receive written proof of loss within 90 days from the date you received services from your Provider. If written proof of loss is not received by us within 15 months of the date of service, we may reject your claim.

The claims submitted by your Providers will usually be sufficient for us to be able to process the claims. Sometimes, we may need additional information from you, your Provider or a third party in order to determine our liability. We need you to cooperate in getting us the needed information. If we are unable to obtain the necessary information, we may deny your claim

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. 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. We do not pay if 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

When you receive Covered Health Services from Network Providers, you should 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 Non-Network 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.

Once a claim is received, we will review the claim for accuracy and validity (e.g., error, abuse and fraud reviews). After that, our reimbursement policies are applied consistently across our membership to Provider claims. We will determine the Eligible Expenses and Maximum Allowed Amount consistent with our policies. 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.

YOUR COVERAGE

WHEN COVERAGE BEGINS

HOW TO ENROLL

Eligible Persons must complete an application. The Enrolling Group will give the necessary forms to you. 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 Confinement 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 must 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

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

ELIGIBLE PERSON

Eligible Person usually refers to an employee or person the Enrolling Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see Section 7: *Definitions*.

Eligible Persons must reside within Our Service Area in the United States.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

DEPENDENT

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 7: *Definitions*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber in the Enrolling Group, only one parent may enroll the child as a Dependent.

WHEN TO ENROLL AND WHEN COVERAGE BEGINS

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

OPEN ENROLLMENT PERIOD

The Open Enrollment Period occurs 30 days prior to the 15th of the month before the Effective Date of the renewal. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the renewal date if we receive the completed application by the 15th of the month prior to the renewal date and any required Premium prior to the renewal date.

NEW ELIGIBLE PERSONS

Eligibility for a new Eligible Person and his or her Dependents begins at the end of the probationary period selected by the Enrolling Group. If we receive the completed application by the 15th of the month, the Effective Date will be the 1st of the following month. If we receive the completed application after the 15th of the month, the Effective Date will be the 1st of the second following month.

ADDING NEW DEPENDENTS

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

For marriage, we must receive notification within 30 days of the event. The eligibility period begins on the date of the event and continues for 30 days. If we receive the completed application by the 15th of the month, the effective date will be the 1st of the following month. If we receive the completed application after the 15th of the month, the effective date will be the 1st of the second following month.

Coverage for the Dependent begins on the date of the event for birth and legal adoption.

In the case of a newborn infant, Coverage begins from the moment of birth and must include Congenital Anomalies and birth abnormalities as an Injury or Sickness.

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. In the case of a child placed for adoption, Coverage begins from the date of adoption or the date of placement, whichever is earlier. We must receive notification and any required Premium within 60 days after the date of adoption or placement.

SPECIAL ENROLLMENT PERIOD

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. Special enrollment periods are triggered by qualifying life events (QLE). Some examples of QLEs are birth or adoption of a child, marriage, divorce, loss of a job and death of a spouse. Your eligibility to enroll and the Effective Date of your coverage depends on what kind of QLE you have. For details on how to enroll due to a QLE, contact us at 855-494-2667.

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. If you have a Marketplace plan, you must add dependents, including newborns, through the Marketplace. The Marketplace rules will govern whether a dependent can be added.

LATE ENROLLEES

A late enrollee means an Eligible Person, or Dependent of an Eligible Person, who does not request coverage under a Policy during a special enrollment period in which the individual was entitled to enroll in the Policy.

A late enrollee/entrant/applicant is an Eligible Person, or Dependent of an Eligible Person who requests coverage 30 days or more from the special enrollment period, and:

- Did not enroll for coverage during when initially eligible.
- Did not have a special enrollment period due to a qualifying event (marriage, birth, adoption or placement for adoption, loss of other coverage).
- Did not enroll timely (e.g. within 30 days from a qualifying event/eligibility date).
- Did not enroll timely (e.g. within 60 days after losing coverage through Medicaid or Children's Health Insurance Plan (CHIP).

Coverage will become effective on the first of the month following 12 months from the date the application is received by us. During this 12-month waiting period no services will be covered nor will Premiums be collected. We will require that the late enrollee remain continuously employed by, or remain a Dependent of an Eligible Person continuously employed by the employer for the entire 12- month waiting period.

WHEN COVERAGE ENDS

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

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

You and your dependent's 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 pay claims for Covered Health Services that you receive before the date on which your coverage ended. 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.

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 (including your Certificate) ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **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: *Definitions* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." If a Dependent reaches age 26 in a calendar year, his/her eligibility will end on the last day of the calendar year or the last day of the month in which the child turns 26 years of age, depending on the Enrolling Group's rules.

- **You Move Out of the Service Area**
  Your coverage ends 60 days following a permanent move out of our Service Area. This includes moves out of state, as well as those within Wisconsin if they are out of our Service Area. You are eligible for a special enrollment period to obtain new coverage through another insurance company.

- **We Receive Notice to End Coverage**
  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**
  Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving Benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees, if any.

OTHER EVENTS ENDING YOUR COVERAGE

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

- **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 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.

CONTINUATION OF COVERAGE

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with Federal or state law.

Continuation coverage under COBRA (the Federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with Federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in Federal law, and we do not assume any responsibilities of a "plan administrator" according to Federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under Federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

QUALIFYING EVENTS FOR CONTINUATION COVERAGE UNDER STATE LAW

If your coverage is terminated due to one of the qualifying events listed below and you were continuously covered under the Policy for a period of at least three (3) months, you may elect to continue coverage, including that of any eligible Dependents.

- Reduction of hours or termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to the death of the Subscriber.
- Termination of coverage due to an annulment or divorce from the Subscriber.

NOTIFICATION REQUIREMENTS AND ELECTION PERIOD FOR CONTINUATION COVERAGE UNDER STATE LAW

The Enrolling Group will provide you with written notification of the right to continuation coverage within five (5) days of the Enrolling Group receiving notice to terminate coverage. You must elect continuation coverage within 30 days of receiving this notification or 30 days after the qualifying event. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

TERMINATING EVENTS FOR CONTINUATION COVERAGE UNDER STATE LAW

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

- The date the Covered Person establishes residence outside of the state.
- 18 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- For the spouse, the date the Subscriber's group coverage ends.
- 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-Network Benefits, unless otherwise indicated in this Certificate.

You are responsible for making sure your Provider, including laboratories, imaging centers surgical centers and hospitals are in Network and that Prior Authorization has been obtained when required. See the Prior Authorization provision to understand which services require Prior Authorization.

NETWORK SERVICES AND BENEFITS

Covered Health Services are provided by Network Providers. 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 Policy. The PCP 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.

No Benefits will be provided for care that is not a Covered Health Service even if performed by a PCP, SCP, or any other 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.

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 Health 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 Health 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 BENEFITS

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

For services rendered by a Non-Network 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 or excluded from coverage;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

OUT OF SERVICE AREA SERVICES

You may receive Covered Health Services at the 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 877.514.2442. You must present your ID card to a Network 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 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 us and Network Providers is an independent contractor relationship. Providers are not our agents or employees, nor are we employees or agents 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 Health Service under your Certificate. We are not 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 Health Services may include financial incentives or risk sharing relationships related to the provision of services by other Providers, including Network Providers, Non-Network Providers, and disease management programs.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

We are 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 us based on the actions of a Provider of health care, services or supplies.

IDENTIFICATION CARD

When you receive care, you must show your ID 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 Network level of Benefits through the end of your employer's 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 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 Network level of benefits until the completion of postpartum care.

The Continuity of Care provisions described above only apply in situations where Providers who were part of the CGHC Network at the time you enrolled leave the Network. They do not apply if you are switching to CGHC coverage from another health insurance company. In addition, 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 the Network for failure to meet credentialing standards.

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 at 877.514.2442 so that we can ensure your claims are paid appropriately. Our Member Services staff can also assist you in selecting another Network Provider for your care.

COMMON GROUND HEALTHCARE COOPERATIVE 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 at the Network Rate of Payment even if received at a Non- Network facility. You may receive services from Non- Network Providers while at a Network Facility. These services will be processed at the Network rate of pay, subject to the Maximum Allowed Amount.

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 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 CGHC 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 the Schedule of Benefits.

The Certificate of Coverage and the Schedule of Benefits are your primary source for accurate information about your Benefits. If you have been provided any other summaries, this Certificate of Coverage and Schedule of Benefits will control.

PRIOR AUTHORIZATION

Your Provider must obtain Prior Authorization for certain Covered Health Services by calling 877.779.7598. This helps us ensure that you receive high quality, cost-effective services. The services requiring Prior Authorization are listed later in this provision. You are responsible for making sure the Prior Authorization has been obtained.

Network Providers will generally obtain Prior Authorization before they provide these services to you. However, it is ultimately your responsibility to ensure Prior Authorization was obtained. Services for which Prior Authorization is required are identified below.

Before receiving Covered Health Services from a Network Provider, contact us at 877.514.2442 to verify that the Hospital, Physician and other Providers are Network and to receive the status of a Prior Authorization request. Our Member Services Representatives can tell you whether the Prior Authorization is approved, denied or is still pending as of 48 hours prior to the time you call.

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.

When you choose to receive certain Covered Health Services obtained from Non-Network Providers, you are responsible for obtaining Prior Authorization before you receive these services. Even if you receive authorization, your Benefit may still be paid at the Non-Network Rate of Payment level.

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 Expenses will be reduced by 50% up to a maximum penalty of $1500 per service. The 50% reduction or penalty amount will apply first, before Deductibles, Coinsurance, or any other plan payment or action. The 50% reduction or penalty amount does not apply toward your Deductible, Coinsurance or Maximum Out-of-Pocket.

A Prior Authorization is not a guarantee benefits will be paid. It is a determination that the services meet the definition of Medically Necessity. We authorize services or supplies based on the information that is available at the time of the authorization. If the bill that is submitted does not match the service authorized, the service may not be paid. The authorization does not guarantee a Covered Person's eligibility or Benefits under this Certificate. We make Benefit determinations in accordance with all the terms, conditions, limitations and exclusions of this Certificate. Your policy must be in effect at the time services are rendered.

COVERED HEALTH SERVICES WHICH REQUIRE PRIOR AUTHORIZATION

The Prior Authorization request for non-emergency or non-urgent situations must be received by us at least fifteen (15) business days prior to the anticipated date of your service/procedure. Please note that for urgent or emergency admissions, Prior Authorization must be obtained within 48 hours after 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 request for Prior Authorization does not guarantee approval of services. 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, you must contact us to request that we extend the original Prior 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.

Services that require Prior Authorization:

- Ambulance - non-emergency air and ground
- Any procedure that could be considered cosmetic
- Biofeedback
- Botox injections
- Chemotherapy — outpatient and oral

- Routine care associated with Clinical trials
- Cochlear implants
- Dental care resulting from an accident
- Dental/Anesthesia - Hospital Ambulatory Surgery Services
- Diagnostic testing including, MRI, MRA, PET, CT Scans, Echocardiogram, psychological testing and neurological testing
- Dialysis (outpatient and home 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)
    - Implantable devices, including but not limited to infusion pumps and neurostimulators
    - Hospital bed(s)
    - Wheelchair(s)
    - Ventilator(s)
- Genetic Testing, including BRCA Genetic Testing except as authorized under Section 1, Number 17 (below)
- Inpatient Confinement (not including observation stay which is less than two (2) midnight)
- Care or confinement levels other than inpatient: Residential, Partial Hospitalization, Intensive Outpatient services, Hospice, Skilled Nursing Facility, and Inpatient Rehabilitation Facility
- Oral surgery
- Out of Service Area care, including all treatment outside the State of Wisconsin
- 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 OptumRX at 855-577-6545
- Prosthetics
- Radiation therapy — outpatient and inpatient
- Reconstructive or plastic surgery procedures, including breast reconstruction surgery following
- Specialty Medications administered in an office or outpatient setting

- Surgery - Outpatient Hospital, free standing surgical center and ambulatory surgery centers (does not include physician office procedures).
- Temporomandibular joint disorder services and procedures, including but not limited to orthognathic procedures
- Transplant evaluation, services, and procedures

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 877.779.7598 by the next business.

We encourage our Covered Persons to take an active and informed role in their health care decision-making and help keep costs down for all Covered Persons of our non-profit cooperative. If you and/or your doctor decide on a course of treatment that is more costly or invasive than an alternate course of treatment that is less expensive OR less invasive but is medically appropriate AND effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, then claims may be reduced or denied. As part of our interpretation of Covered Health Services in the Certificate under Section 7*: Health Services Definitions*, we reserve the right to define our clinical protocols. 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 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 subject to the Maximum Allowed Amount. For Network Benefits, you are not responsible for any difference between the Maximum Allowed Amount and the amount the provider bills. You are also responsible for any Deductible, Copayment or Coinsurance. 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 Maximum Allowed Amount, and also payment of any applicable Deductible, Copayment or Coinsurance. 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: *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. We are happy to assist you in understanding what Providers participate in our Network, but it is your responsibility to select your Provider.

Our Network Provider health systems are in the best position to help you select a doctor. Both Aurora Healthcare and Bellin Health System offer phone numbers that their patients may call for assistance in finding a Provider. If you would like to contact Aurora Healthcare, you may call 888.720.2012. If you would like to contact Bellin Health System, you may call 888.758.7373. While this may be helpful to you in choosing a physician, please understand that this does not relieve you of the responsibility of ensuring the physician you choose is in network. Please visit our website at cgcares.org/find-a-doctor/ or call us at 877.514.2442 to make certain the doctor you select is in Network.

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 us at 877.514.2442.

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, except as provided in the Continuity of Care section of this Certificate.

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.

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 another 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, 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.

Please note that even if we treat a Non-Network provider as a Network Provider for the purposes of level of payment, the Non-Network Provider can still bill you for amounts over and above the Maximum Allowed Amount.

SECTION 1: COVERED HEALTH SERVICES

BENEFITS FOR COVERED HEALTH SERVICES

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

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

- 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 provision occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.
- Proper proof of loss (which most of the time constitutes a claim sent directly to us from your Provider) was submitted within 90 days, but in no event, later than 15 months of the date of service.

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 Deductible, Copayment and/or Coinsurance).
- 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).

Benefits for covered prescription drugs administered in a Physician's office are subject to the terms and conditions under the Covered Health Services section of this Certificate.

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

Coverage includes Covered Health Services such as 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.

Air ambulance is only covered when your health condition requires immediate and rapid ambulance transportation that ground transportation cannot provide, and one of the following applies:

- Your pickup location cannot be easily reached by ground transportation.
- Long distances or other obstacles, like heavy traffic, could stop you from getting care quickly if you traveled by ground ambulance.

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.

Prior Authorization is required for non-emergency air and ground transportation. See Prior Authorization provision of this Certificate.

2. AUTISM SPECTRUM DISORDER SERVICES

The following definitions apply for purposes of Autism Spectrum Disorders:

"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.

Covered Health Services include the following:

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 bythe 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 ofage.

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 servicestreatment.
- 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 **are not covered as** Autism Spectrum Disorders Expenses (this is not an all-inclusive list):

- Services rendered where Mental retardation is the primary diagnosis as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- 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 Member 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 Member'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.

Coverages includes Covered Health Services for biofeedback for the treatment of:

- Headaches
- Spastic Torticollis
- Urinary Incontinence
- Post-traumatic stress disorder

4. BOTOX INJECTIONS

Coverage includes Covered Health Services for the use of botulinum toxin 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. CHIROPRACTIC SERVICVES

Coverage includes Covered Health Services for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. include diagnostic testing, manipulations and treatment.

6. CLINICAL TRIALS

Coverage includes Covered Health Services for routine patient care costs incurred during participation in a qualifying clinical trial within the parameters defined below.

Routine patient costs include 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. This does not include the cost of the clinical trial itself. 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 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:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the above four entities or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
        - 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.

7. COCHLEAR IMPLANT

Coverage includes Covered Health Services for Cochlear implant 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.

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
- Outpatient Rehabilitation Services for post-cochlear implant aural therapy are limited to 30 visits per year.

8. CONGENITAL HEART DISEASE SURGERIES

Coverage includes Covered Health Services for 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.

9. CONTRACEPTIVE MEDICATIONS AND DEVICES

Coverage includes Covered Health Services for 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 include certain:

- Contraceptive oral medications
- Flexible birth control vaginal ring
- Hormone-releasing birth control implant
- Contraceptive patch
- Intrauterine contraceptive (IUC)
- Hormone-releasing and non-hormone releasing intrauterine devices (IUD)
- Subcutaneous injection
- All contraceptive medications and devices defined within the formulary as preventive will be dispensed at no cost to the member.

10. DENTAL SERVICES — ACCIDENT ONLY

Coverage includes Covered Health Services for dental services when all of the following are true:

- Treatment is necessary because of accidental damage to the teeth and/or gums.
- Dental services are received from a Doctor of Dental Surgery, Oral Surgeon or Doctor of Medical Dentistry.
- 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.

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

Coverage includes Covered Health Services for 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.

12. DIABETES SERVICES

Coverage includes Covered Health Services 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.

13. DIAGNOSTIC TESTING

Coverage includes Covered Health Services for 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.
- Neurological testing.
- Psychological testing.

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.

14. DURABLE MEDICAL EQIPMENT

Coverage includes Covered Health Services provided to you by a Network Physician and obtained from a Network Durable Medical Equipment Provider. See Section 2: *Exclusions and Limitations*; D. Devices, Appliances and Prosthetics.

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 as determined by Us. 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 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.

Please see Section 2: *Exclusions and Limitations*; D. Devices, Appliances and Prosthetics for any non -covered Durable Medical Equipment. 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.

15. EMERGENCY HEALTH SERVICES— OUTPATIENT

Coverage includes Covered Health Services that are required to stabilize or initiate treatment in an Emergency. Medically Necessary services that we determine meet the definition of Emergency Care will be covered whether rendered by Network or Non-Network Provider. Emergency Health Services rendered by a Non-Network Provider will be covered at the Network rate of pay subject to the Maximum Allowed Amount. We will not pay charges in excess of the Maximum Allowed Amount. The Member may be responsible for charges in excess of 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 Confinement).

16. ENDOSCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

Coverage includes Covered Health Services for diagnostic and therapeutic endoscopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic endoscopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic endoscopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical endoscopic procedures, which are for the purpose of performing surgery. Benefits for surgical endoscopic procedures are described under Surgery - Outpatient. Examples of surgical endoscopic 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.)

17. GENETIC TESTING AND COUNSELING

Coverage includes Covered Health Services for:

- 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

Coverage includes Covered Health Services for Habilitative Services 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).

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. Benefits are limited to 20 visits per year.

19. HEARING AIDS

Coverage includes Covered Health Services 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.

Hearing aids are limited to one hearing aid per ear every 36 months. Please note that Covered 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

Coverage includes Covered Health Services received from a Home Health Agency that 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.

Benefits are limited to 60 visits per year. One visit equals up to 4 hours of skilled care services.

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 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

Coverage includes Covered Health Services for Hospice care as recommended by your Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. 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 Health Services and supplies listed below 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. Covered Health Services include:

- 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 your Physician and the hospice medical director must certify that you are terminally ill and generally have less than six months to live, and 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 Health 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. INPATIENT CONFINEMENT

Coverage includes Covered Health Services and supplies provided during an Inpatient Confinement in a Hospital. Benefits are available for:

- Room and board in a Semi-private Room (a room with two or more beds). A private room will be paid at the semi-private room rate unless the private room is required due to the nature of the hospitalization, such as an orthopedic room in a special care unit or a Semi-private room is not available.
- Ancillary Services and supplies -services received during the Inpatient Confinement 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

Coverage includes Covered Health Covered Health Services for an individual who meet the following:

- 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;
- 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;
- 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.

Coverage is limited to 60 days per year.

24. KIDNEY DISEASE TREATMENT

Coverage includes Covered Health Services for inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-related services.

25. LABORATORY SERVICES

Coverage includes Covered Health Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Clinic or Alternate Facility including:

- Lab tests when an appropriate diagnosis ispresent.
- 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 licensedPhysician. Laboratory tests for preventive care are described under Preventive Care Services.

26. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Coverage includes Covered Health Services for 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 andassessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/DayTreatment.
- Intensive OutpatientTreatment.
- Services at a Residential TreatmentFacility.
- Individual, family and group therapeuticservices.
- Crisis intervention.

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.

27. NEWBORN

Coverage includes Covered Health Services for:

- 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.

28. NUTRITION AND MEDICAL NUTRITION EDUCATION

Coverage includes Covered Health Services for 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.

29. ORAL SURGERY

Coverage includes Covered Health Services for oral surgery 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:
    - Gingivectomy or Gingivoplasty – Excision of loose gum tissue to eliminate infection.
    - Gingival curettage.
    - Gingival flap procedure, including root planing.
- Osseous surgery.
- Alveoloplasty – the leveling of structures supporting teeth or the purpose of fitting dentures.

30. OSTOMY SUPPLIES

Coverage includes Covered Health Services for ostomy supplies 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.

31. PARENTERAL AND ENTERAL NUTRITION IN THE HOME

Coverage includes Covered Health Services for oral enteral and parenteral nutrition when all of the criteria are met:

- 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.

32. PHARMACEUTICAL PRODUCTS — OUTPATIENT

Coverage includes Covered Health Services for 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.

33. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES

Coverage includes Covered Health Services for physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis, including outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive.

34. PHYSICIAN'S OFFICE SERVICES — SICKNESS AND INJURY

Coverage includes Covered Health 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. Benefits 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, 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.

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

One second opinion per injury or illness by a Network Provider is covered regarding Covered Health Services and Prior Authorization is obtained if needed. Prior Authorization is required if an out-of-network second opinion is requested.

35. PODIATRY SERVICE

Coverage includes Covered Health Services for podiatry services limited to:

- 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.

36. PREGNANCY— MATERNITY SERVICES

Coverage includes Covered Health Services for a Covered Person's Pregnancy including all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. A Covered Person's Pregnancy includes a Covered Person serving as a surrogate host/gestational carrier. Both before and during a Pregnancy, Benefits include the services of a genetic counselor related testing and treatment, if Medically Necessary, when provided or referred by a Physician.

37. PREVENTIVE CARE SERVICES

Coverage includes Covered Health Services for Preventive Care Services that fall into one of two categories under this Policy:

1. Mandated by the Patient Protection and Affordable Care Act (PPACA); or
2. Not Mandated by the PPACA.

There are also preventive services that are not Covered Health Services. For example, those that are not Medically Necessary, which will be denied.

There are many services listed below that Covered Persons may have that will not be paid as preventive services. Some examples:

1. Your first screening colonoscopy after you turn 50 is paid at 100%, but polyps are found. Instead of being on a 10 year screening schedule, you are put on a 5 year screening schedule. Your next colonoscopy 5 years later will not be paid at 100%.
2. You have a pap smear test that is abnormal, so you are required to repeat it after 6 months. The next pap smear test at 6 months will not be covered at 100%. No future pap smears will be covered at 100% until you go 3 years without an abnormal test.
3. Your doctor orders full blood work at your annual preventive exam. The exam and only some of the blood tests (those mandated by PPACA) will be paid at 100%.

Services that fall into Category 1 are discussed below, and are generally not subject to cost-sharing. Services that fall into Category 2, are paid under the Policy but are subject to cost-sharing, including deductible and co-insurance.

For Category 1. Services, it is important to know that not all of the services listed below will be covered without cost-sharing. The procedure, test or treatment must be considered a "screening test," meaning you have it done to determine if you have a condition, but you have no symptoms. It is also important to understand that the services listed below are still subject to all of the provisions of the Policy, including medical necessity and the exclusions.

Category 1 Services are 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 PPACA, without applying a Deductible, Coinsurance or Copayment when these services are provided by a 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
    - Ages 50-59
- 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
- Syphillis Screening
- Statin preventive medication – ages 40-75 with certain risk factors
- Tobacco Use Screening & Interventions in Adults and Pregnant Women
- Tuberculosis Screening

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; and Breastfeeding Interventions
- 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 Adolescents ages 12 to 18
- 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)
- Hemogloinopathies 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
- Iron Supplements
- Measles

- Mumps
- Rubella
- Meningococcal-Child
- Pneumococcal - Pneumonia
- Rotavirus
- Varicella-Chicken Pox
    - 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. Additional Services may be added when required by law.

More information about the preventive services coverage required under the Affordable Care Act can be found at www.commongroundhealthcare.org/preventive.

38. PROSTHETIC DEVICES

Coverage includes Covered Health Services for 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.

39. RECONSTRUCTIVE PROCEDURES

Coverage includes Covered Health Services for 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 a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. 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 877.514.2442 for more information about Benefits for mastectomy-related services.

Benefits are generally not provided for breast reconstruction surgery when the reason for the reconstruction is not related to a malignancy of the breast or area of the breast. 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 covered procedure.

40. REHABILITATION SERVICES AND HABILITATIVE SERVICES — OUTPATIENT THERAPY

Coverage includes Covered Health Services for short-term outpatient rehabilitation services, limited to:

- Physical therapy, limited to 20 visits per year.
- Occupational therapy, limited to 20 visits per year. This does not include services as described under Autism Spectrum Disorder Services in this section.
- Speech therapy, limited to 20 visits per year. This does not include services as described under Autism Spectrum Disorder Services in this section.
- Cardiac rehabilitation therapy, limited to 36 visits per year and with 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
- Post-cochlear implant aural therapy, limited to 30 visits per year.
- Cognitive rehabilitation therapy, limited to 20 visits per year.
- Pulmonary rehabilitation therapy, limited to 20 visits per year.

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.

42. SKILLED NURSING FACILITY

Coverage includes Covered Health Services for services and supplies provided in a Skilled Nursing Facility. Benefits are available for:

- Up 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.

41. STERILIZATION SERVICES

Coverage includes Covered Health Services for the following sterilization services:

- Tubal Ligation which meets Prior Authorization requirements.
- Vasectomy in Physician's office. If done as ambulatory surgery or inpatient Prior Authorization is required.

44. SURGERY — OUTPATIENT

Coverage includes Covered Health Services for Surgery and related services received on an outpatient basis at a Hospital or in a Physician's office within the parameters of this section.

Benefits under this section include certain endoscopic procedures. Examples of surgical endoscopic 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 provision.

45. TEMPOROMANDIBULAR JOINT DISORDER SERVICES

Coverage includes Covered Health Services for 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.

Surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

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

Benefits are not available for cosmetic or elective orthodontic care, periodontic care or general dental care.

46. THERAPEUTIC TREATMENTS — OUTPATIENT

Coverage includes Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital 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 services 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.

47. TRANSFUSIONS/INFUSIONS

Coverage includes Covered Health Services 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.

48. TRANSPLANTATION SERVICES

Coverage includes Covered Health Services for organ and tissue transplants when ordered by a Physician.

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.

Transplant services must be received at a Designated Facility using a Designated Provider. All transplant services require Prior Authorization. We have specific guidelines regarding Benefits for transplant services. Contact at 877.514.2442 for information about these guidelines.

49. URGENT CARE CENTER SERVICES

Coverage includes Covered Health Services received at an Urgent Care Center.

50. URINARY CATHETERS (INTERMITTENT AND INDWELLING

Coverage includes Covered Health Service for intermittent and indwelling urinary provided in an appropriate setting when Medically Necessary. A Covered Person must 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

51. VISION EXAMINATIONS

Coverage includes Covered Health Service for a Covered Person without eye disease or diagnosis beyond refraction to detect vision impairment, received from a health care Provider in the Provider's office. Benefits include:

- An annual eye exam for children 18 years old and under 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 above.

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 provision. No benefits are available for adult eye exams without eye disease or diagnosis.

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.

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

The following services are not Covered Health Services under this Certificate:

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.

B. AUTISM SPECTRUM DISORDER SERVICES

The following services are not Covered Health Services under this Certificate:

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
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.
3. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
4. 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.
5. Treatments for the primary diagnoses of learning disabilities, and 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

The following services are not Covered Health Services under this Certificate:

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.
2. 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.
3. Endodontics, periodontal surgery and restorative treatment are excluded except as related to trauma.

4. 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, Oral Surgery and Temporomandibular Joint Disorder Services in Section 1: *Covered Health Services*.

5. 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 and Temporomandibular Joint Disorder Services in Section 1: *Covered Health Services*.
6. Dental braces (orthodontics).
7. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly for cosmetic or appearance purposes.

D. DEVICES, APPLIANCES AND PROSTHETICS

The following services are not Covered Health Services under this Certificate:

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

The following services are not Covered Health Services under this Certificate:

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

The following services are not Covered Health Services under this Certificate:

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 except for preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples of excluded services 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.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

10.

G. MATERNITY SERVICES

The following services are not Covered Health Services under this Certificate:

1. Elective abortions: except when performed to save the life/health of the mother and in instances of rape or incest.
2. Home or intentional out of Hospital deliveries.
3. Amniocentesis or Chorionic Villi Sampling (CVS) 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

The following services are not Covered Health Services under this Certificate:

1. Non-prescribed medical supplies, which include but are not limited to:
    - Compression stockings and/or elastic stockings
2. Over the counter medical supplies, which include but are not limited to:
    - Bandage
    - Gauze and dressings
    - Antibiotic and anti-itch creams

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 in 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 AND SUBSTANCE USE DISORDERS

The following services are not Covered Health Services under this Certificate:
Mental Health:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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.
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.
8. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
9. Mental retardation with autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Autism Spectrum Disorder Services in Section 1: Covered Health Services.
10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized us. This exclusion does not apply to Mental Health Services provided as the result of an Emergency detention, commitment or court order.
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.

Substance Use Disorders:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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, or their equivalent clinics.
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, us. This exclusion does not apply to services provided as the result of an Emergency detention, commitment or court order, the services will be covered.
6. Room and board at Transitional Care facilities.
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.

J. NUTRITION

The following services are not Covered Health Services under this Certificate:

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

The following services are not Covered Health Services under this Certificate:

1. Television.
2. Telephone.
3. Beauty/barber service.
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.
    - Cold therapy systems.
    - Continuous passive motion devices.
    - Electric Scooters.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers, except when Medically Necessary and ordered by a physician for use with a CPAP machine.
    - Humidifiers.
    - Jacuzzis.
    - Massage equipment, beds, and chairs.
    - Mattresses.
    - Medical alert jewelry and phone systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Phototherapy light fixtures or sun lamps
    - Pillows.

- Power-operated vehicles, and its accessories.
- Radios.
- Saunas.
- Scales.
- Stair lifts and stair glides.
- Step stools and standing tables.
- Strollers.
- Safety equipment.
- Special toilet seats and accessories.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. PHYSICAL APPEARANCE

The following services are not Covered Health Services under this Certificate:

1. Cosmetic Procedures. See the definition in Section 7 *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.
    - Removal of warts, skin tags, and other benign skin lesions.
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

The following services are not Covered Health Services under this Certificate:

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.
10. Biofeedback except covered items in Section 1-3.
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.
12. Surgical and non-surgical treatment of obesity.
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

The following services are not Covered Health Services under this Certificate:

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

The following services are not Covered Health Services under this Certificate:

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, health services for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which Benefits are available or would have been required 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, no-fault auto insurance, or similar legislation.
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. TRANSPLANTS

The following services are not Covered Health Services under this Certificate:

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.

6. Donor costs, except cost directly related to organ removal from the donor.

R. TRAVEL

The following services are not Covered Health Services under this Certificate:

1. Health services provided in a foreign country, unless required as Emergency Health Services. This does NOT include transportation expenses necessary to return you to the United States for care.

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*.

S. TYPES OF CARE

The following services are not Covered Health Services under this Certificate:

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).

T. VISION AND HEARING

The following services are not Covered Health Services under this Certificate:

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. Adult eye exams without disease or a specific diagnosis.
5. 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.
6. 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 hearingaid.

   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.

U. ALL OTHER EXCLUSIONS

The following services are not Covered Health Services under this Certificate:

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 7: *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 before Your Effective Date 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, for which a charge would not ordinarily be made in the absence of coverage under the Policy, or for which a Provider, pharmaceutical manufacturer or similar entity pays a portion of the charge. This includes any coupons, savings cards, grants or gift/cash cards you may receive. Such amounts will not be credited to your Deductible, Coinsurance or Maximum Out-Of-Pocket limit
6. Health services for which billing is not received by us within 15 months of the date of service.
7. 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.
8. Charges in excess of Eligible Expenses or in excess of any specified limitation, including the Maximum Allowed Amount.
9. Charges for which our liability cannot be determined because a Covered Person, Provider, facility, or other individual or entity within 30 days of our request, failed to:
   - Authorize the release of all medical records to us and other information we requested.
   - Provide us with information we requested about pending claims or other insurance coverage.
   - Provide Us with information as required by any contract with Us or a network including, but not limited to, repricing information.
   - Provide us with information that is accurate and complete.
   - Have any examination completed as we requested.
10. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
11. Autopsy.
12. Dry needling, prolotherapy.
13. Coma Stimulation programs.
14. Court ordered care, unless medically necessary and otherwise covered under the Certificate
15. Services and supplies rendered outside the scope of the provider's license.
16. Foreign language and sign language services.
17. 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 includes services to treat complications that arise from the non- Covered Health Service.

Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure.

COMMON GROUNDHEALTHCARE COOPERATIVE OUTPATIENT PRESCRIPTION DRUG

OUTPATIENT PRESCRITION DRUG INTRODUCTION

COVERAGE POLICIES AND GUIDELINES

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.

IDENTIFICATION 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 full amount for the Prescription Drug Product charged 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, and any deductible that applies.

Generally, there are no Benefits are available for prescriptions filled at a Non-Network Pharmacy. However, in the event of an emergency, we will pay the Maximum Allowed Amount.

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.

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 section of you 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 NETWORKPHARMACY

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

Please access ***WWW.COMMONGROUNDHEALTHCARE.ORG*** **or** call 855-577-6545 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.

2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

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. Charges for drugs that are not listed in a Drug List.

6. Charges for any amount over the Maximum Allowed Amount.

7. Charges for any difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy or Designated Specialty Pharmacy Provider been used.

8. Charges for Compounded Medications that contain one or more active ingredients that are not covered under this plan; combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan; combination drugs or drug products that are manufactured and/or packaged together, unless authorized by Us under the Outpatient Prescription Drug Benefits section before they are dispensed

9. 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.

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

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

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

13. Unit dose packaging of Prescription Drug Products.

14. Medications used for cosmetic purposes.

15. 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.

16. 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.

17. Prescription Drug Products when prescribed to treat infertility.

18. 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.

19. 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.

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

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

22. 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.

23. 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.

24. 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.

25. Any portion of the cost of a Prescription Drug Product that is paid, waived or reimbursed by a pharmaceutical manufacturer or related entity. This includes any coupons, savings cards, grants or gift/cash cards.

26. 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.

27. Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns; anabolic steroids are not excluded if Medically Necessary.

28. Charges for drugs used to treat, impact or influence: obesity; morbid obesity; weight management; sexual function, dysfunction or inadequate sexual energy, performance or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

29. Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition.

30. Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Provider.

31. Charges for postage, handling and shipping charges for any drugs.

32. Charges for drugs for which prior authorization is required by Us and is not obtained.

33. Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member. For purposes of this exclusion, "employer" includes but is not limited to any corporation, partnership, sole proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

34. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity. For purposes of this exclusion, "entity" includes but is not limited to any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

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. You must notify Us if you have any other coverage that constitutes a "Plan" described below.

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.

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.

C. 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.

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.

D. 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 Network Provider and approved by us.

E. 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:

The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the Benefits under any other Plan.

A. 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 isprimary.

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.

B. A Plan may consider the Benefits paid or provided by another Plan in determining its Benefits only when it is secondary to that otherPlan.

C. 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 beenmarried:

(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. You must cooperate with Us in providing the information necessary to adjudicate your claims. Failure to do so may result in delay and claim denial.

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 Enrolling Group's Benefit Plan and how it may affect you. We help finance or administer the Enrolling Group's 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 the Enrolling Group's Benefit Plan will cover or pay for the health care that you may receive. The Policy pays for Covered Health Services, which are more fully described in this Certificate.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. If the Policy does not pay, you will be responsible for the cost.

We may use information about you to identify 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 AND ENROLLING GROUPS

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.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under the Enrolling Group's Benefit Plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit Plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your rights under ERISA, contact the Enrolling Group or the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.

YOUR RELATIONSHIP WITH PROVIDERS AND ENROLLING GROUPS

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 the Maximum Allowed Amount.
- 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.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

NOTICE

We provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

CONFORMITY WITH FEDERAL AND STATE LAWS

We comply with all applicable state and federal laws. This Certificate will conform with the minimum requirements of all applicable laws if there is no governing Certificate provision or a conflicting Certificate Provision. With regard to time frames listed in this Certificate: if the minimum or maximum legal requirement is changed following the issuance of this certificate, we reserve the right to apply the minimum legal requirement.

STATEMENTS BY ENROLLING GROUP OR SUBSCRIBER

All statements made by the Enrolling Group or 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 the Enrolling Group to void the Policy after it has been in force for a period of two (2) 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. These incentives may also be designed to comply with the Quality Improvement Strategy provision of the Affordable Care Act.

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. 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 AND SERVICES OFFERED 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. In addition, we may offer free or discounted access to services, discount programs or other incentives to help you stay well. These incentives are not Benefits and do not alter or affect your Benefits. They can be discontinued at any time. 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 Enrolling Group. 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.

Failure to cooperate in obtaining information necessary to properly adjudicate your claims may result in delay and denial of those claims. This applies to all Benefit determinations, including those for coordination of benefits and subrogation.

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.

SECOND OPINION AND MEDICAL EXAMINATION OF COVERED PERSONS

We reserve the right to require an ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs at our expense to determine whether the service or supply meets
the definition of a Covered Health Service.

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.
- Your employer.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault 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 we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorney's 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 attorney's 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 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 tort feasors 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 mightobtain.
- 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 inerror.

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.

We may also choose to recover overpayments by offsetting the overpayment from a future payment made to the overpaid Provider.

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 Appeals/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 Enrolling Group, including this Certificate, the Application, the Schedule of Benefits, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

SECTION 7: 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.
- Mental Health Services or Substance Use Disorder Services including on an 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.

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.

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

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, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorders Services, or their symptoms.

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 a Dependent child of the Subscriber. 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 Dependent child under 26 years of age.
- 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 calendar year or the last day of the month in which the child turns 26 years of age, depending on the Enrolling Group's rules.

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. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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 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 Expense(s) – the amount we determine that we will pay for Benefits subject to the Maximum Allowed Amount.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States in the coverage area.

Emergency - a serious medical condition or symptom of a sudden onset and severity 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 received in a Hospital emergency facility, freestanding emergency medical facility, or comparable emergency facility necessary for the treatment of an Emergency.

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

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

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.

This does not apply to routine patient costs associated with clinical trials for which Benefits are available as described under Clinical Trials 1: *Covered Health Services*.

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 – is an acute medical facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:

- Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care.
- Be staffed by an on duty physician 24 hours per day.
- Provide nursing services supervised by an on duty registered nurse 24 hours per day.
- Maintain daily medical records that document all services provided for each patient.

- Provide immediate access to appropriate in-house laboratory and imaging services.
- Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.
- Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and step-down units.

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

Inpatient Confinement - admission to a Hospital, Skilled Nursing Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility or other licensed facility for a stay of at least 24 hours for which a charge is incurred for room and board observation.

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.

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.

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.

Institution of Higher Learning – A technical college; an institution within the University of Wisconsin System; or any college or university that grant's a bachelor's degree or higher.

Manipulation Therapy – physical therapy consisting of the therapeutic application of 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 Health 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 may be determined using any of the following:
- An amount the Plan and Provider negotiate;
- The billed amount;
- An amount obtained via a Network utilized by Plan that has an agreement with the non-participating provider;
- An amount derived from the amount the Provider of a similar type and/or in the same similar geographic region bills for the same or similar services or goods as determined by data from an

- independent third party, including but not limited to Medicare and Medicaid, based on many factors such as charge data, relative values, estimated costs, and reimbursement schedules.
- For certain designated specialty providers, we may apply a reimbursement methodology based on percent of billed charges.
- For services for which there is no published rate from CMS, we will pay 50% of the reasonable billed charge.
- For Pharmaceutical Products, we will pay an amount derived from the average wholesale price or the wholesale acquisition costs.

Medically Necessary (Medical Necessity)- 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.
- Is approved in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.
- Consistent with our clinical policies and criteria.

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.

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 Illness - those mental health or psychiatric diagnostic categories that are listed in the current

Diagnostic and Statistical Manual of the American Psychiatric Association.

Network and Network Provider- 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 - Benefits provided for Covered Health Services rendered by a Network provider. Refer to the Schedule of Benefits 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/Pharmacy – a Non-Network provider/facility/pharmacy is one which has not contracted with us for reimbursement at a negotiated rate. We offer coverage for Non-Network providers, but your patient responsibility would be higher than it would be if you were seeing a Network provider or using a 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. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - The maximum amount you are required to pay for Medical and Prescription Drugs in a single year.

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* or by calling they Pharmacy Benefit Management Customer Service Department at 855.577.6545.

Plan (or We, Us, Our) – Common Ground Healthcare Cooperative which provides Benefits to Members for the Covered Services described in this Certificate.

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 the Enrolling Group that includes all of the following:

- The Master Group Policy.
- This Certificate.
- The Schedule of Benefits.
- The Enrolling Group's application.
- Amendments and Riders (if applicable).
- Notices.

These documents make up the entire agreement that is issued to the Enrolling Group.

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 the Prior Authorization provision of this Certificate. Failure to obtain Prior Authorization when required will result in application of the penalty listed in the Prior Authorization provision.

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.

Provider-includes a person, supplier, or facility that provides health services.

Rate of Payment- the Coinsurance percentage applied to a benefit payment. Your Network Rate of Payment is higher than your Non- Network Rate of Payment, which means you owe less than when you use Network Providers.

Rehabilitative – healthcare 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.

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 – the document that accompanies this Certificate and lists the benefits and the benefit limitations covered under this Policy.

Semi-private Room - a room with two or more beds.

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.

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

Specialty Care 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.

Student – a person attending an accredited vocational, technical, adult education school or college on a full-time basis consisting of a minimum of 12 credit hours per semester.

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 Enrolling Group.

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. For the purposes of this Certificate, the term substance abuse has the same meaning as substance use.

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.

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. In order for a service, including medications, to be considered proven, they must meet the following criteria:

- Be supported by 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.)
- Be supported by 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.***

Urgent Care Center - a facility that is not a regular Provider office, an Emergency Room, or a Hospital 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

Brand-name - a Prescription Drug Product that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or that we identify as a Brand-name product, based on available data resources including, but not limited to, Medispan, 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.

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.

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* or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

P**rescription 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* or by calling the Pharmacy Benefit Management Customer Service Department at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

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 an adverse determination.

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 within 3 years after the date your claim was processed or you were advised of an adverse benefit determination. 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 the you or your designee have filed a request for an Expedited Independent External Review.

An expedited request will be resolved no later than 72 hours after receipt of the request.

INDEPENDENT EXTERNAL REVIEW

Independent External Review is available to you within 4 months 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 Non- Network services when you believe that the clinical expertise of the out- of-plan Non- 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 Health 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:

HHS Federal Review
Request MAXIMUS Federal
Services 3750 Monroe
Avenue
Suite 705
Pittsford, NY 14534

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.

Expedited 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 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 providedin 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 COMMISIONER 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.

Note, 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 must 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 for the institution to provide you with health care, to protect your health and safety or the health and safety of others or 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. As of February 17, 2010, our business associates 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 healthinformation.

- **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***.

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.

STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH PLAN COVERAGE

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your COBRA continuation rights. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a Certificate of creditable coverage, in writing, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a Certificate of creditable coverage by calling the number on your ID card.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

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).

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.