



COMMON GROUND HEALTHCARE COOPERATIVE

GROUP CERTIFICATE OF COVERAGE, AMENDMENTS AND NOTICES

Certificate ID Number: CGHC.PB.3001.2018

Effective Date: January 1, 2019

Offered and Underwritten by Common Ground Healthcare Cooperative

Common Ground Healthcare Cooperative

[120 Bishop's Way, Suite 150
Brookfield, WI 53005-6271]
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877-514-2442

IMPORTANT NOTICES

This Certificate of Coverage outlines the terms and conditions of your insurance coverage. This is the contract that Common Ground Healthcare Cooperative holds with you in consideration of your employers' application, your application and the premium payment.

It is important that you read your policy carefully and store it in a place where you can find it quickly. This Certificate of Coverage, along with any attached riders or amendments, will explain your benefits and other important information about your health insurance coverage. The following are important disclosures you should read through regarding your policy.

CERTIFICATE OF COVERAGE IS PART OF THE POLICY

This Certificate is part of the Policy and is a legal document between Common Ground Healthcare Cooperative (CGHC) and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. In addition to this Certificate the Policy includes the Schedule of Benefits, your Employer's Master Group Policy, any Amendments and Riders, Notices and your Application.

PLEASE 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.

YOUR RIGHT TO RETURN POLICY

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

GUARANTEED RENEWABILITY

This Policy is guaranteed renewable unless one of the exceptions in **Section 3: When Coverage Begins and Ends** becomes applicable. You must be eligible for insurance your premiums must be paid to remain insured.

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.

IMPORTANT NOTICES

LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-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 Providers and information on out-of-pocket expenses by calling our Member Services department at [877.514.2442] or by clicking on the “Find a Doctor” button located on our website home page at 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 provision 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 plan through the Marketplace.

STATEMENTS MADE IN YOUR APPLICATION

Please submit any corrections to your application in writing within ten days if any information submitted in your application is incorrect or incomplete. Misstatements or omissions in the application could cause an otherwise valid claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and other information shown on the application is correct and complete.

CHANGES TO THE CERTIFICATE OF COVERAGE AND EFFECTIVE DATES

We have the right to change, interpret, modify, withdraw, add Benefits, or to terminate the Policy, as permitted by law, without your approval. We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Certificate. When that happens, we will notify you and send new Certificate, Rider or Amendment pages. No one can make any changes to the Policy unless those changes are in writing.

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

This 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 Central Time on the date of your termination. This Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to the ‘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.

NOTICES

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.

CERTIFICATE OF COVERAGE

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SECTION 1: INTRODUCTION

Thank you for becoming a member of Common Ground Healthcare Cooperative (CGHC). This Certificate of Coverage (referred to simply as your Certificate) describes your covered Benefits, Exclusions and Limitations as well as your rights and responsibilities as an insured member of Common Ground Healthcare Cooperative. We encourage you to read your Certificate, your Schedule of Benefits and attached Riders and/or Amendments carefully. You may call us at [877.514.2442] to request that a printed copy of this Certificate be mailed to you.

This Certificate is your main source of information regarding the Benefits available to you under the Policy. If there is a conflict between this Certificate and any summaries provided to you by the Enrolling Group, this Certificate will control with respect to Benefits for Covered Persons.

HOW TO USE THIS DOCUMENT

Please review the table of contents for this document to understand how the document is organized. Many of the sections of this Certificate are related to other sections of the document so you may not have all the information you need by reading just one section.

We encourage you to review the Benefits and the limitations of this Certificate by reading the Schedule of Benefits along with **Section 7: Covered Health Services** and **Section 8: Exclusions and Limitations**. You should also carefully read **Section 11: General Legal Provisions** to better understand how this Certificate and your Benefits work. Please do not hesitate to contact us at [877.514.2442] if you have questions about the limits of the coverage available to you.

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 4: Terms and Definitions**. When we refer to an Enrolling Group, we are typically referring to your Employer, but this term also applies to any other defined or otherwise legally established group, to whom the Policy is issued.

Because this Certificate is part of a legal document, we also want to include definitions that will help you understand the document. If a word is capitalized in the document, it likely has a special meaning and defined in **Section 4: Terms and Definitions**. You can refer to **Section 4: Terms and Definitions** as you read this document to have a better understanding of your Certificate.

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

PLEASE DO NOT 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, claims, Providers, Premium, invoices or other questions, please call our Member Services Department at [877.514.2442]. This number is also listed on your ID card. Helping our members understand their Benefits is an important part of our mission as a non-profit, member-governed Cooperative, and it will be our pleasure to assist you when you call.

SECTION 2: RIGHTS AND RESPONSIBILITIES

All members should understand their rights and their responsibilities as a member of a non-profit health insurance cooperative where members have a financial stake in the decisions they make.

MEMBER RIGHTS

You and all CGHC members have the right to:

1. Receive information about CGHC, its services, its practitioners and providers and member rights and responsibilities.
2. Be treated with respect and dignity by CGHC employees and its contracted health care providers and professionals. Please know we will not discriminate in the service or benefits offered to you based on race, religion, national origin, sex, age, sexual preference, type of illness or financial status.
3. Have privacy of medical and financial records maintained by CGHC and its health care providers in accordance with existing law.
4. Be informed about appropriate and alternative treatment options and their risk, regardless of cost or Benefit coverage.
5. Participate with health practitioners in making decisions about your health care and treatment.
6. Voice complaints or concerns about CGHC or any of its network providers and contracted vendors.
7. Appeal any decision made by CGHC and to receive a response within a reasonable amount of time.
8. Make recommendations regarding CGHC's Member Rights and Responsibilities policy.
9. Choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes.
10. Have a safe, secure, clean and accessible health care environment.
11. Have access to emergency health care services in cases where a "prudent layperson" acting reasonably would believe that an emergency existed.

MEMBER RESPONSIBILITIES

You and all CGHC members have the responsibility to:

1. Be enrolled and pay required contributions toward your premium. To be enrolled and receive benefits, you must be enrolled in accordance with the Policy issued to your Enrolling Group and you must qualify as an eligible person or his or her dependent as defined in **Section 4: Terms and Definitions**.
2. Comply with all provisions of the policy outlined in the Certificate of Coverage, including Prior Authorization requirements.
3. Know and confirm your benefits before receiving treatment.
4. Show your ID card before receiving health care services. Showing your ID card will help ensure timely and accurate submission of your claims.
5. Pay your share of your care by paying applicable co-payments, coinsurance and deductibles to participating practitioners and providers when services are received for most Covered Health Services. These payments are due at the time of service or when billed by the Provider.

RIGHTS AND RESPONSIBILITIES – Continued

6. Deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. Under limited circumstances when we pay an Out-of-Network Provider listed in the Limited Health Services from Out-of-Network Providers provision, you may also be required to pay any amount that exceeds the Maximum Allowed Amount.
7. Follow agreed upon instructions and guidelines for care.
8. Decide on 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.
9. Understand health problems and develop mutually agreed upon treatment goals, to the degree possible.
10. Provide accurate information, to the extent possible, so that CGHC and your practitioner may properly care for you, or to make an informed coverage determination.
11. Use practitioners and providers affiliated with the appropriate CGHC Provider Network to receive the highest level of benefits. It is your responsibility to select the In-Network health care professionals who will deliver care to you. Please visit our website at www.CGCares.org/find-a-doctor or call us at [877.514.2442] to make certain the doctor you select is in our Network. The availability of providers in our Network is subject to change. You may find that an In-Network Provider is not accepting new patients or has left the Network. If a Provider leaves the Network or is otherwise not available, you may choose another Network Provider to receive Benefits under this Policy.
12. Pay full charges for all excluded services and items. Review **Section 8: Exclusions and Limitations** to become familiar with this Certificate's exclusions.
13. Provide us with written notice about losses/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 process the claims. Sometimes, we may need additional information from you, your Provider or a third party 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.

MORE INFORMATION ABOUT YOUR RESPONSIBILITY TO MAKE REQUIRED CONTRIBUTIONS

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.

OUR RESPONSIBILITIES

1. 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.

RIGHTS AND RESPONSIBILITIES – Continued

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 Certificate, such as a pharmacy benefits administrator. 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.

2. **Contract with Health Care Providers:** We arrange for Physicians and other health care professionals and facilities to participate in our Provider Networks. Please be certain you understand which Provider Network your Enrolling Group has selected for your plan, either Empower or Envision, and select your Providers accordingly. Our Provider Networks are subject to change at any time. Please contact us at [877-514-2442] to check on the availability of an In-Network provider. 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.
3. **Pay In-Network and Out-of-Network Providers.** When you receive Covered Health Services from In-Network Providers, you should not have to submit a claim to us. 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.
4. **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. 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, Out-of-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.

SECTION 3: WHEN COVERAGE BEGINS AND ENDS

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.

WHO IS ELIGIBLE FOR COVERAGE

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent within the parameters of this certificate and applicable law. Eligible Person usually refers to an employee or person the Enrolling Group and CGHC determines 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 4: Terms and Definitions**.

Eligible Persons must reside within our Service Area or work for an employer with a primary address in our Service Area. 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 4: Terms and Definitions**.

WHEN TO ENROLL

Enrollment should be done through your Enrolling Group. Except as described below, Eligible Persons may not enroll themselves or their dependents.

- **During an 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.
- **During a 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.
- **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 or 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.

WHEN COVERAGE BEGINS AND ENDS – Continued

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.

- **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.
- **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)).

WHEN COVERAGE BEGINS

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.

DEDUCTIBLE CREDIT

An Enrolling Group that begins coverage on a date other than January 1 may receive deductible credit for amounts accumulated toward the other carrier's deductible. The Enrolling Group must submit a deductible credit report from the prior carrier within 90 days of the Enrolling Group's effective date. Any deductible credit information received after 90 days will not be credited. The report must include group name, member names, amount of deductible met in the current calendar year.

WHEN COVERAGE BEGINS AND ENDS – Continued

IF YOU ARE HOSPITALIZED WHEN YOUR COVERAGE BEGINS

If you are 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 received on or after your first day of coverage if 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 reasonably possible.

IF YOU ARE ELIGIBLE FOR MEDICARE

Please see Medicare Eligibility in **Section 10: Coordination of Benefits** which has important information about Medicare and CGHC Coverage.

GENERAL INFORMATION ABOUT WHEN COVERAGE ENDS

We may discontinue coverage under this Certificate and Policy at any time for the reasons explained in this section, as permitted by law. You and your dependents' entitlement to Benefits automatically end 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 your termination date, even if the medical condition that is being treated occurred before the date your coverage ended.

EVENTS ENDING YOUR COVERAGE

For the events listed below, the effective date of the termination is specified. If more than one category is applicable, your coverage will end on the earliest of the dates.

1. **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.
2. **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.
3. **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.
4. **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.
5. **We do not receive Premium Payment:** If the Enrolling Group fails to pay Premiums within 31 days after of the date they are due, then we may terminate your coverage as of the last day of the last month for which we received Premiums.

WHEN COVERAGE BEGINS AND ENDS – Continued

6. **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, or submission of false, misleading or fraudulent claims or documentation related to claims.

During the first two years this 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 this 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 this 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 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

WHEN COVERAGE BEGINS AND ENDS – Continued

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, and 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.

SECTION 4: TERMS AND DEFINITIONS

ADVERSE BENEFIT DETERMINATION – A denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person’s eligibility to participation in a plan. Adverse Benefit Determination also includes a rescission of coverage.

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 or 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.

APPEAL – A formal written request to reconsider a previous Adverse Benefit Determination by us.

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).

BENEFIT(S) – The maximum amount that will be allowed for a Covered Health Service under this Policy subject to applicable limits, Deductibles, Copays, Coinsurance and Out of Pocket Maximums. Benefits may be expressed in many ways, such a dollar amount, number of days or the number of services. 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 – This document providing details of your Benefits. Also see the definition of Policy.

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

COMPLAINT – Your verbal expression of dissatisfaction with us or any In-Network Provider.

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 – We may use the term “covered” to communicate that Benefits will apply to a service subject to applicable limits, Deductibles, Copays, Coinsurance and Out of Pocket Maximums. Covered is not paid in full.

COVERED HEALTH SERVICE(S) – services, supplies, or Pharmaceuticals that are:

- Medically Necessary, and
- Described as a Covered Health Service in this Certificate under **Section 7: Covered Health Services** and in the Schedule of Benefits, and
- Not otherwise excluded in this Certificate under **Section 8: Exclusions and Limitations**, and
- Provided to prevent, diagnose or treat a Pregnancy, Sickness, Injury, Mental Illness, Substance Use Disorder Service, or their symptoms.

TERMS AND DEFINITIONS – Continued

COVERED PERSON(S) - 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 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 to be delivered safely and effectively.

DEDUCTIBLE - the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Covered Health Services. The amount that is applied to the Deductible is calculated based on Eligible Expenses. The Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits for any applicable Deductible amount and how it applies.

DEPENDENT - the Subscriber's legal spouse or an unmarried Dependent child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner only if the Enrolling Group chooses to cover Domestic Partners. A Dependent does not include anyone who is also enrolled as a 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).

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:

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

TERMS AND DEFINITIONS – Continued

A Dependent also includes an adult child who meets all 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.

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.

DESIGNATED FACILITY - a facility that has entered 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 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.

DESIGNATED PHYSICIAN - a Physician that we have 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.

DIAGNOSTIC CARE – Tests or services that are done to determine the presence of a medical condition when symptoms are present.

DURABLE MEDICAL EQUIPMENT - medical equipment that is all 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.

Please review **Section 8: Exclusions and Limitations**; D. Devices, Appliances and Prosthetics for items that are specifically excluded from coverage.

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

ELIGIBLE EXPENSES – amount we determine 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.

TERMS AND DEFINITIONS – Continued

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 from an ambulance provider or 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 proven to be of benefit for the diagnosis or treatment of a Sickness or Injury; or
- Not generally used or recognized by the medical community as safe, effective, and appropriate for diagnosis or treatment of a Sickness or Injury;
- In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
- 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).
- Obsolete or ineffective for the treatment of a Sickness or Injury; or
- 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.
- 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 subject to FDA oversight.

This does not apply to routine patient costs associated with clinical trials for which Benefits are available as described under **Section 7: 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.

GRIEVANCE – Any written complaint or dispute expressing dissatisfaction with any aspect of CGHC operations or activities or any Network Provider.

HABILITATIVE SERVICES - health care services that help a person keep, learn, or improve skills and functioning

TERMS AND DEFINITIONS – Continued

for daily living. 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 – A 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 the following requirements:

- Be licensed by the state in which the services are rendered and accredited by an accreditation agency as determined by us, including, the Joint Commission 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.

IN-NETWORK OR NETWORK PROVIDER - when used to describe a provider of Covered Health Service, 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 an Out-of-Network Provider for other Covered Health Services and products. The participation status of providers will change from time to time.

IN-NETWORK BENEFITS OR IN-NETWORK LEVEL OF BENEFITS - How Covered Health Services rendered by an In-Network provider apply to your benefits including limitations, deductibles, copays, coinsurance and Out-of-Pocket Maximums. Refer to the Schedule of Benefits for details about how In-Network Benefits apply. In-Network Benefits does not include the amount we pay health care providers. Please see the definition for Maximum Allowed Amount to understand how In-Network and Out-of-Network Providers will be paid under this policy.

IN-NETWORK PHARMACY/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 and has agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

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.

TERMS AND DEFINITIONS – Continued

INTENSIVE OUTPATIENT TREATMENT - a structured outpatient mental health and 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 and as appropriately accredited as determined by us.

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 an In-Network provider or Out-of-Network provider as determined by us based upon what we deem payable for Covered Health Services for a Member. For an In-Network provider, 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. An In-Network provider is not allowed to charge you above this amount for a service.

For Out-of-Network Providers, the Maximum Allowed is typically derived from the amount the Provider of a similar type and/or in the same or 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 services for which there is no CMS published Medicare rate, we will pay based upon the State of Wisconsin Medicaid reimbursement rate. For services for which there is no published rate from CMS or State of Wisconsin Medicaid, we will pay 50% of the reasonable billed charge.

We may also determine the Maximum Allowed Amount for an Out-of-Network Provider 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;
- For certain designated specialty providers, we may apply a reimbursement methodology based on percent of billed charges.

Please know we cannot prevent an Out-of-Network Provider from billing you above what we have determined to be our Maximum Allowed Amount for payment. For Pharmaceutical Products, we will pay an amount derived from the average wholesale price or the wholesale acquisition costs.

TERMS AND DEFINITIONS – Continued

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)- health care services provided to prevent, evaluate, diagnose or treat a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all 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 costlier 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.
- Provided 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.

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.

NON-NETWORK/OUT-OF-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 your Benefit Plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

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-NETWORK PROVIDER/FACILITY/PHARMACY – a Non-Network or Out-of-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.

TERMS AND DEFINITIONS – Continued

OUT-OF-POCKET MAXIMUM - The maximum amount you are required to pay for Medical and Prescription Drugs in a single year. Amounts paid for non-covered services, including amounts in excess of the Maximum Allowed Amount, do not count towards your Out-of-Pocket Maximum.

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 find out which tier a particular Pharmaceutical Product has been assigned by calling the Pharmacy Benefit Member Service Department at [855.577.6545] or at www.CommonGroundHealthCare.org.

PLAN (OR WE, US, OUR) – Common Ground Healthcare Cooperative which provides Benefits to Covered Persons for the Covered Health 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 you that includes all the following:

- This Certificate
- The Enrolling Group's Master Policy
- The Schedule of Benefits.
- Your application.
- Amendments and Riders.
- Notices.

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

PRACTITIONER/QUALIFIED PRACTITIONER – includes but is not limited to a physician, nurse anesthetist, physician's assistant, nurse practitioner or midwife. Regarding medical services provided to a Covered Person, a Qualified Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

PREGNANCY - includes all the following:

- Prenatal care
- Childbirth and postnatal care
- Any complications associated with Pregnancy.

TERMS AND DEFINITIONS – Continued

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

PRESCRIPTION DRUG/PHARMACEUTICAL PRODUCT – a drug or a medication product or device approved by the US Food and Drug Administration and only available only by prescription that can be dispensed only upon presentation of a legally valid prescription.

PREVENTIVE/ROUTINE CARE – There are three types of preventive care an individual may receive, but only two are Covered Services under your Plan:

1. Benefits **include** certain Preventive Care that is required by the Affordable Care Act to be covered by insurance companies at 100% (no cost to Covered Person) if the care is received In-Network;
2. Benefits **include** certain Preventive Care that is not required by the Affordable Care Act to be covered at 100% that may be subject to Deductibles, Copays and Coinsurance; and
3. Benefits **do not include** Preventive Care that is not covered because it is not medically necessary or is otherwise listed as an Exclusion.

Preventive Care may sometimes be called Routine Care and is provided on an outpatient basis at a Primary Care Physician's office when there is not a health or medical concern present. Any medical concerns you discuss with your Primary Care Physician may result in tests that would be considered Diagnostic Care and not Preventive Care and subject to Deductibles, Copays and Coinsurance.

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

PRIOR AUTHORIZATION – the advance, written authorization, with appropriate documentation for specific medical services or treatment. Services requiring Prior Authorization are specified in Article V of the Certificate and in the Schedule of Benefits. Failure to obtain Prior Authorization when required will result in application of the penalty listed in the Prior Authorization section.

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.

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

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.

TERMS AND DEFINITIONS – Continued

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. The Service Area may change from time to time. Contact us to determine the exact geographic area we serve.

SICKNESS - physical illness or disease.

SKILLED NURSING FACILITY - a Hospital or nursing facility that is licensed and operated as required by law, and as appropriately accredited as determined by us.

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.

SPECIALTY PRESCRIPTION DRUG PRODUCT – a Prescription Drug Product that that is 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 Member Service Department at [855.577.6545].

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 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

TERMS AND DEFINITIONS – Continued

environment and support for recovery. These arrangements may be used with ambulatory treatment when treatment alone does not offer the intensity/structure needed to assist with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide Covered Persons 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. 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.

URGENT CARE – Treatment or services provided for a Sickness or Injury that develops suddenly and unexpectedly that requires immediate treatment, but is not of severity to be considered Emergency Treatment.

URGENT CARE CENTER - a facility that provides for the delivery of Urgent Care services and that generally provides unscheduled, walk-in care. An Urgent Care Center is not a regular Provider office, an Emergency Room, or a Hospital.

SECTION 5: HOW TO OBTAIN COVERED SERVICES

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, the Certificate of Coverage and Schedule of Benefits will control.

In-Network Providers are the key to providing and coordinating your health care services. Benefits under your plan will be paid at their highest level when you obtain Covered Health Services from In-Network Providers. Services you obtain from any Provider other than a Network Provider are considered an Out-of-Network service and are covered at the level described in your Schedule of Benefits.

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 next section, **Section 6: Prior Authorization**, to understand which services require Prior Authorization.

ACCESSING BENEFITS

As a PPO Plan, you may choose to receive Covered Health Services from In-Network or Out-of-Network Providers. In-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 this 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 licensed physician or specialists who is an In-Network Provider. We have final authority to determine coverage eligibility for a service based upon our Medical Necessity determination.

For services rendered by In-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 any applicable Coinsurance, Copayments, and/or Deductible. 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. You are also responsible for services that are not Covered Health Services, including those that are not Medically Necessary or excluded from coverage.

We do not decide what care you need or will receive. You and your Physician make those decisions.

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 which 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. Each network partner offers a phone number their patients may call for assistance in finding a Provider. 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.

HOW TO OBTAIN COVERED SERVICES – Continued

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

We reserve the right to change the providers participating in our Network at any time. Before obtaining services, you should always verify the Network status of a Provider. 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. 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 provisions of this Certificate on page 23.

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. Please refer to your designated Network Provider directory.

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 must 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.

DESIGNATED FACILITIES AND DESIGNATED PHYSICIANS

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

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

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

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

ELIGIBLE EXPENSES

Eligible Expenses are the amount we determine that we will pay for Benefits subject to the Maximum Allowed Amount as defined in **Section 4: Terms and Definitions**.

HOW TO OBTAIN COVERED SERVICES – Continued

If you receive care from In-Network providers, you are not responsible for any difference between the Maximum Allowed Amount and the amount the Provider bills. You are responsible for any applicable Deductible, Copayment or Coinsurance.

For services received from Non- Network Providers under this Certificate, you are responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the Out-of-Network Provider bills you and the Maximum Allowed Amount, and payment of any applicable Deductible, Copayment or Coinsurance. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines.

EMERGENCY SERVICES

In-Network Level of Benefits apply to Covered Emergency Health Services that are provided by an In-Network or Out-of-Network Provider. Emergency Services provided by an Out-of-Network Emergency provider will be paid subject to the Maximum Allowed Amount. This means that the Emergency Provider may bill you for the difference between the Maximum Allowed Amount and their billed charges. Please be aware you may receive services from Out-of-Network Providers while at an In-Network Facility.

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 travel 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 will not receive the Network level of Benefits if the travel/national network Provider provides services within our Service Area.

RELATIONSHIP OF PARTIES (US AND NETWORK PROVIDERS)

The relationship between us and In-Network Providers is an independent contractor relationship. Network 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 because 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 In-Network Provider's agreement for providing Covered Health Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Network Providers, Out-of-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.

HOW TO OBTAIN COVERED SERVICES – Continued

IDENTIFICATION CARD

You must show your ID card every time you request health care services. 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. Only a Covered Person 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) was part of the CGHC Network when you enrolled but later terminates Network participation without cause, you have the right to continue to access that Provider at the In-Network Level of Benefits through the end of the calendar 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 In-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. For continuity of their care, Covered Persons new to the Plan who are in their third trimester of pregnancy may continue to receive obstetric care from their Out-of-Network provider through the completion of post-partum care. Covered person in their first or second trimester of pregnancy at the time of initial enrollment must transition their care to an In-Network provider.

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 processed appropriately. Our Member Services staff can also assist you in selecting another Network Provider for your care.

SECTION 6: PRIOR AUTHORIZATION

Your In-Network 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.

In-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.

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 will 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.

Before receiving Covered Health Services, contact us at [877.514.2442] to verify that the Hospital, Physician and other Providers are Network Providers 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.

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 Deductible, 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 Medical 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. 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 non-emergency or non-urgent outpatient services.

PRIOR AUTHORIZATION – Continued

If your Provider determines that additional care beyond the services specified or the length of time originally authorized is needed, 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.

Services that require Prior Authorization:

- Any procedure that could be considered cosmetic
- Botox injections
- Routine care associated with Clinical trials
- Cochlear Implants
- Diagnostic testing including, MRI, MRA, PET, CT Scans, Echocardiogram, psychological testing and neuropsychological testing
- 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
 - 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 and Counseling, including BRCA Genetic Testing
- Inpatient Confinement (not including observation stay which is less than two (2) midnights)
- Care or confinement levels other than Inpatient: Residential, Partial Hospitalization, Intensive Outpatient services, Skilled Nursing Facility, and Inpatient Rehabilitation Facility.
- Oral surgery
- 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 our Pharmacy Benefit Manager, OptumRX, at [855-577-6545]
- Prosthetics
- Reconstructive or plastic surgery procedures, including breast reconstruction surgery following mastectomy
- 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 (TMJ) disorder services and procedures, including but not limited to orthognathic procedures
- Transplant evaluations, 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 day.

PRIOR AUTHORIZATION – Continued

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 this Certificate under **Section 4: Terms and 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 delivered to you.

If you choose to receive a service that has been determined not to be a 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 this 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 10: Coordination of Benefits**. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 7: 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. Remember that this section of the document cannot be fully understood without also reading other sections of this document including **Section 8: Exclusions and Limitations**. Benefits are available only if all the following are true:

- Covered Health Services must be Medically Necessary and not Experimental/Investigational or resulting from 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 by In-Network Providers except as listed in the Limited Covered Health Services from Out-of-Network Providers provisions on page 21.
- Covered Health Services are received while this 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 this 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 your Schedule of Benefits (sent as part of your welcome packet) 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 **Section 7: Covered Health Services** of this Certificate.

HOW WE USE HEADINGS IN THIS SECTION

To help you find Covered Services more easily, we use headings (for example 1. Ambulance Services below). The headings group services, treatments, items, or supplies that fall into a similar category. A description of the Covered Services will appear under the headings. A heading does not create, define, modify, limit or expand Covered Services.

Please note that in listing services or examples, when we note "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."

COVERED HEALTH SERVICES – Continued

1. AMBULANCE SERVICES

Covered Health Services include emergency ambulance services provided by a licensed ambulance service (either ground or air ambulance) and includes transportation to the nearest Hospital where Emergency Health Services can be performed.

Emergency ambulance services are often provided by Out-of-Network ambulance services, which means that the services will be paid at the Maximum Allowed Amount. We will not pay charges over the Maximum Allowed Amount, and Out-of-Network providers may decide to bill Members for charges in excess of the Maximum Allowed Amount.

Emergency air ambulance is only covered (again, at the Maximum Allowed Amount) 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.

Prior Authorization is required for non-emergency air and ground transportation. Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) may be a Covered Service and paid at the Maximum Allowed Amount when a Covered Person's medical condition is such that any other form of transportation is contraindicated and is being transported between medical facilities for one of the following reasons:

- From an Out-of-Network Hospital to an In-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.
- To and from one medical facility to another to obtain medically necessary diagnostic or therapeutic services, such as CT/MRI or dialysis services, not the needed service is not available at the originating facility.

Learn more about the Prior Authorization provisions of this Certificate in **Section 6: Prior Authorization**.

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

COVERED HEALTH SERVICES – Continued

treatment with Intensive level services or, for an individual who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Intensive level and non-intensive level services include but are not limited to speech, occupational and behavioral therapies. Covered Health Services include the following:

INTENSIVE LEVEL AUTISM 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 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 evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified professional, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meeting and active involvement of the Enrolled Dependent child's family and treatment team for implementation of the therapeutic goals developed by the team.
- The Enrolled Dependent child is directly observed by the qualified intensive level provider or qualified intensive level professional at least once every two months.
- Beginning after the Enrolled Dependent child is two years of age and before the Enrolled Dependent child is nine years of age.

Intensive level services will be covered for up to four cumulative years. We may credit against any previous intensive level services the Enrolled Dependent child received against the required four years of intensive level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person 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 is considered 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.

COVERED HEALTH SERVICES – Continued

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 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 AUTISM SERVICES

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

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

Benefits will be provided for evidence-based therapy that is consistent with all 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 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.

COVERED HEALTH SERVICES – Continued

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.

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 an Eligible Person who is staying in a residential treatment center, inpatient treatment or day treatment facility
- Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of an Eligible Person's home
- Claims we have determined are fraudulent
- Treatment provided by parents or legal guardians who are otherwise Qualified Providers, Qualified Supervising Providers, Therapists, Qualified Professionals or Paraprofessionals for treatment provided to their own children

3. BIOFEEDBACK

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

Covered Health Services include biofeedback for the treatment of:

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

COVERED HEALTH SERVICES – Continued

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 SERVICES

Coverage includes chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license, including diagnostic testing (subject to prior authorization requirements), manipulations and treatment.

6. CLINICAL TRIALS

Routine patient care costs that would otherwise be covered under this plan incurred during participation in a qualifying clinical trial are covered within the parameters defined below.

Routine patient costs including 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 or Sickness, Injury or complications resulting from the clinical trial. 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

COVERED HEALTH SERVICES – Continued

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, device, or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in your direct clinical management; and/or a service that is clearly inconsistent with widely accepted and established standards of care for your diagnosis.

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

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

- A Cochlear Implant is a Covered Health Service 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.

COVERED HEALTH SERVICES – Continued

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 may be Covered Health Services subject to the parameters of CGHC's Prescription Drug Formulary.

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 device (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 the following are true:

1. Treatment is necessary because of accidental damage to the teeth and/or gums.
2. Dental services are received from a Doctor of Dental Surgery, Oral Surgeon or Doctor of Medical Dentistry.
3. The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period if you do so within 60 days of the Injury and 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.

COVERED HEALTH SERVICES – Continued

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 Such as 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.

COVERED HEALTH SERVICES – Continued

13. DIAGNOSTIC TESTING

Covered Health Services include diagnostic tests or procedures generally performed when you have specific symptoms to detect or monitor your condition, and are subject to prior authorization requirements in **Section 6: Prior Authorization**.

Covered Health Services include but are not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA) – prior authorization required
- Magnetic Resonance Imaging (MRI) prior authorization required
- CT imaging - prior authorization required
- 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 Health Services
- Echocardiograms- prior authorization required
- Bone density studies
- Positron emission tomography (PET scanning)(prior authorization required)
- Diagnostic Tests as an evaluation to determine the need for a covered transplant Procedure
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocardiograms
- Neurological Testing
- Psychological and Neuropsychological Testing(prior authorization required)

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 EQUIPMENT

Covered Health Services include Durable Medical Equipment prescribed by an In-Network Physician and obtained from an In-Network Durable Medical Equipment Provider when possible. Durable Medical Equipment that exceeds \$1,000 in cost (purchase or cumulative rental) require a Prior Authorization as described in **Section 6: Prior Authorization**. Also, see **Section 8: Exclusions and Limitations** under D. Devices, Appliances and Prosthetics for limitations on Covered Durable Medical Equipment.

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 Durable Medical Equipment.

COVERED HEALTH SERVICES – Continued

Covered Durable Medical Equipment, subject to Prior Authorization requirements for equipment that exceeds \$1,000 (purchase or cumulative rental) and applicable limitations, 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, however, air conditioners, humidifiers except as necessary with a CPAP, 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 8: Exclusions and Limitations** under 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 Covered Durable Medical Equipment should be purchased or rented. We may choose to pay rental up to the purchase price not to exceed 13 months. Durable Medical Equipment must be purchased or rented from an In-Network provider. 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 us at 877.514.2442.

COVERED HEALTH SERVICES – Continued

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 Health Services will be covered whether rendered by Network or Out-of-Network Providers. Emergency Health Services rendered by a Out-of-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 Out-of-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, including 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 in a Physician’s office within the provisions of this section.

Diagnostic endoscopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic endoscopic procedures include but are not limited to colonoscopy, sigmoidoscopy, endoscopy (Upper GI), Endoscopic Retrograde Cholangiopancreatography (ERCP) and Ureteroscopy.

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

17. GENETIC TESTING AND COUNSELING

Covered Health Services include Genetic Testing and Genetic Counseling if it is not Experimental or Investigational Services as defined in **Section 6: Prior Authorization** is required.

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 (for example, therapy for a child who isn’t walking or talking at the expected age).

Both of the following conditions must be met for coverage of Habilitative Services that are not related to Autism Spectrum disorder.

COVERED HEALTH SERVICES – Continued

1. You must have one of the following diagnoses:
 - Developmental delay
 - Developmental coordination disorder
 - Mixed developmental disorder
 - Developmental speech or language disorder
2. 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. Prior authorization is not required, but physical or occupational therapy is limited to 20 visits per year each.

Habilitation Services and diagnoses not specifically listed above are not covered, including but not limited to respite care, day care, recreational care, residential treatment (except as described in this section under Mental Health and Substance Use Disorders), social services, custodial care, or education services of any kind.

These limits do not include services as described under Autism Spectrum Disorder Services which are described on page 29.

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, including services, diagnoses, surgery, and therapy provided in connection with the hearing aid.

Hearing aids are limited 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 medically necessary services received from a Home Health Agency that meet all of the following criteria:

- The service is ordered by a Physician.
- The service is 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.
- The 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.

COVERED HEALTH SERVICES – Continued

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

- It must be delivered or supervised by licensed technical or professional medical personnel (e.g., OT, ST, PT or a social worker) in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care or for maintenance.

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 medically necessary hospice care for Covered Persons as recommended by a physician. Hospice care is a program that provides comfort and support services for the terminally ill. Care may be provided in the home or at a hospice facility. We may have programs that provide an enhanced or reduced benefit based on the care setting you choose. Please contact us at 877-514-2442 for more information.

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.

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

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.

COVERED HEALTH SERVICES – Continued

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 Health 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) or in a private room where 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

Covered Health Services include inpatient rehabilitation 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 inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-related services.

COVERED HEALTH SERVICES – Continued

25. LABORATORY SERVICES

Coverage includes Medically Necessary services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Clinic or Alternate Facility. These include:

- Lab tests when medically necessary and appropriate for the diagnosis of a Sickness or Injury and ordered by a licensed physician;
- Infertility diagnostic tests unless a diagnosis of infertility has already been established. If a diagnosis has been established, no additional fertility testing is covered.

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 including those received as 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 and performed by a licensed, In-Network mental health professional. Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnostic testing
- Treatment planning
- Referral services
- Medication management
- Inpatient (prior authorization required)
- Partial Hospitalization/Day Treatment (prior authorization required)
- Intensive Outpatient Treatment (prior authorization required)
- Services at a residential treatment facility (prior authorization required)
- Individual, family and group therapeutic services
- Crisis intervention
- Eating Disorders

Substance Use Disorder Services include those received in 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 and Treatment planning
- Detoxification (sub-acute/non-medical)
- Inpatient services (prior authorization required)
- Partial Hospitalization/Day Treatment (prior authorization required)
- Intensive Outpatient Treatment (prior authorization required)
- Services at a residential treatment facility (prior authorization required)
- Referral services
- Medication management, including methadone maintenance
- Individual, family and group therapeutic services
- Crisis intervention

COVERED HEALTH SERVICES – Continued

27. NEWBORN BENEFITS

Covered Services include the following:

- Nursery room, board and care. Coverage includes an inpatient stay at the time of delivery of at least:
 - 48 hours for the mother and newborn child (if the child is added to the plan) following a vaginal delivery
 - 96 hours for the mother and newborn child following a cesarean section delivery
- 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

Covered Health Services for oral surgery are limited to the following:

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

COVERED HEALTH SERVICES – Continued

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; and
- 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. Prior authorization is required. We may have programs in which you may receive an enhanced or reduced benefit based on the care setting you choose. Please contact us for more information.

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 using your prescription drug card.

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.

COVERED HEALTH SERVICES – Continued

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.

35. PODIATRY SERVICES

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 Covered Persons with certain chronic conditions as we determine, such as diabetes.

36. PREGNANCY — MATERNITY SERVICES

Coverage for maternity include all pregnancy-related medical services for prenatal care, postnatal care, delivery, and any related complications. Prior Authorization is required. A Covered Person's Pregnancy includes a Covered Person serving as a surrogate host/gestational carrier.

Coverage includes an inpatient stay at the time of delivery of at least:

- 48 hours for the mother and newborn child (if the child is added to the plan) following a vaginal delivery
- 96 hours for the mother and newborn child following a cesarean section delivery

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. Prior authorization is required.

Breast pumps are covered 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.

COVERED HEALTH SERVICES – Continued

If you are in your second or third trimester of pregnancy and your provider terminates participation in the CGHC provider network for reasons other than cause, you may have Continuity of Care rights which are described on page 23.

For continuity of their care, Covered Persons new to the Plan who are in their third trimester of pregnancy may continue to receive obstetric care from their Out-of-Network provider through the completion of post-partum care. Covered person in their first or second trimester of pregnancy at the time of initial enrollment must transition their care to an In-Network provider.

37. PREVENTIVE CARE SERVICES

There are three types of preventive care an individual may receive, but only two are considered Covered Services under your CGHC Plan:

- Category 1: Your Benefits **include** certain Preventive Care that is required by the Affordable Care Act to be Covered by insurance companies at 100% (no cost to Covered Persons) as long as the care is received In-Network;
- Category 2: Your Benefits **include** certain Preventive Care received In-Network that is not required by the Affordable Care Act to be covered by insurance companies that may be subject to Deductibles, Copays and Coinsurance;
- Category 3: Benefits **do not include** Preventive Care that is not covered because it is not medically necessary or is otherwise listed as an Exclusion.

Two examples of a Preventive Care that would be paid at no cost to a member is 1) a colonoscopy for someone that has no history of polyps or any other medical concern related to the colon and is getting the colonoscopy simply because it is recommended for individuals who have reached the age of 45 and 2) an annual wellness check-up with an In-Network Primary Care Provider.

However, please be aware that any tests that are done as part of an annual wellness visit are billed separately from the office visit and may be subject to applicable Deductibles, Copays and Coinsurance. An example of this is a comprehensive metabolic exam, which is sometimes done as part of a full blood panel, that would be subject to Deductibles, Copays and Coinsurance.

Other examples of tests that are Covered but are subject to deductibles, copays and coinsurance:

1. Your first screening colonoscopy after you turn 45 is paid at 100%, but polyps are found. Instead of being on a 10-year screening schedule, you are put on a five year screening schedule. Your next colonoscopy five 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 six months. The next pap smear test at six months will not be covered at 100%. Future pap smears will not be covered at 100% until you go three years without an abnormal test.
3. Your doctor orders full blood work at your annual preventive exam. Only certain of the blood tests (those mandated by PPACA) will be paid at 100% while others would be subject to Deductibles, Copays and Coinsurance.

COVERED HEALTH SERVICES – Continued

PREVENTIVE CARE SERVICES THAT MAY BE COVERED AT 100%

For Category 1 services described above that may be covered at 100%, it is important to know that limitations apply that may impact whether the service will be covered in full. 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 must also be appropriate for your age as described and provided on an outpatient basis at an In-Network Physician’s office or an Alternative Facility. It is also important to understand that the services listed below are still subject to all of the provisions of this Policy, including Medical Necessity and any limitations or exclusions.

Category 1 Preventive Care services have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, and have been proven to have a beneficial effect on health outcomes. They 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 Affordable Care Act, without charging a deductible, coinsurance or copayment when these services are provided by an In-Network provider in a primary care 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.

AFFORDABLE CARE ACT REQUIRED PREVENTIVE HEALTH SERVICES FOR ADULTS:

- Abdominal Aortic Aneurysm one-time Screening for men aged 65-75 with a history of smoking
- Alcohol Misuse Screening & Counseling
- Aspirin Use Ages 50-59, if ordered by physician and a prescription is received from the provider, and the prescription is filled using the pharmacy Benefit
- 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 when preventive, not diagnostic- — Age 45 and older includes colonoscopy, sigmoidoscopy, test for occult blood, polyp removal and related pathology when the colonoscopy is preventive and not diagnostic
- Prostate Cancer Screening — Men aged 40 years and older
- Depression Screening
- Diabetes Type 2 Screening
- Diet Counseling and obesity Screening (Screening and Counseling) in Adults
- Syphilis Screening

COVERED HEALTH SERVICES – Continued

AFFORDABLE CARE ACT REQUIRED PREVENTIVE HEALTH SERVICES FOR ADULTS (CONTINUED):

- Vaccinations/Immunizations:
 - Hepatitis A and B
 - Herpes Zoster-Shingles
 - Human Papilloma Virus (HPV)
 - Influenza -flu shot
 - Meningococcal
 - Pertussis
 - Pneumococcal – Pneumonia
 - Tetanus
 - Varicella-Chicken Pox
- Statin preventive medication – ages 40-75 with certain risk factors
- Tobacco Use Screening & Interventions in Adults and Pregnant Women
- Tuberculosis Screening

AFFORDABLE CARE ACT REQUIRED PREVENTIVE HEALTH SERVICES FOR WOMEN:

- Prenatal Test/Screening for Anemia and Bacteriuria
- 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 for females under 25 years if sexually active, or females 25 years and older with multiple sex partners, pregnant or of child bearing years
- Contraception — See medications and devices listed on our Prescription Drug formulary
- Sterilization — Tubal Ligation for women with reproductive capacity
- Domestic & Interpersonal Violence Screening & Counseling
- Folic Acid, if ordered by a physician and filled using the 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 and 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

COVERED HEALTH SERVICES – Continued

AFFORDABLE CARE ACT PREVENTIVE SERVICES FOR CHILDREN:

- Physician Visit (well-child/well-baby/health check) and Developmental Screening through age 21
- Behavioral Assessments
- Autism Screening
- Blood Pressure Screening
- Cervical Dysplasia Screening — Females under 18 and sexually active
- Depression Screening in Adolescents aged 12 to 18
- Dyslipidemia Screening — Ages 2 through 21
- Gonorrhea preventive Medication
- Hearing and Vision Screening in children
- Height, Weight and Body Mass Index Measurements
- Hematocrit or Hemoglobin Screening (Anemia)
- Hemoglobinopathies or sickle cell screening
- Childhood Vaccinations/Immunizations:
 - Diphtheria
 - Haemophilus Influenza Type B (HIB)
 - Hepatitis A and B
 - Human Papilloma Virus (HPV)
 - Inactivated Polio Virus
 - Influenza (flu) Shot
 - Measles, Mumps and Rubella
 - Meningococcal-Child and Pneumococcal - Pneumonia
 - Rotavirus and Varicella-Chicken Pox
- Iron Supplements, if ordered by physician and prescription is filled using the pharmacy benefit
- Lead Poisoning Screening
- Sexually Transmitted Infection (STI) Prevention Counseling & Screening
- Tuberculin Testing (TB skin test)
- Skin Cancer Prevention Counseling

AFFORDABLE CARE ACT 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 a Sickness 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.CGCares.org/preventive.

COVERED HEALTH SERVICES – Continued

38. PROSTHETIC DEVICES

Coverage includes Covered Health Services for external prosthetic devices that replace a limb or a body part but is limited to:

- Replacement of natural or artificial limbs and eyes, ears and nose no longer functional due to physiological change or malfunction beyond repair.
- 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. The prosthetic device must be ordered or provided by, or under the direction of a Physician.

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.

39. RECONSTRUCTIVE PROCEDURES

Coverage includes breast reconstructive procedures when the primary purpose of the procedure is 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 when the primary result of the procedure is not a changed or improved physical appearance. Prior Authorization is required.

Benefits for reconstructive procedures include breast reconstruction following mastectomy including of the non-affected breast to achieve symmetry and nipple and areola reconstruction/tattoo. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at 877.514.2442 for more information.

CGHC considers reduction mammoplasty medically necessary if there is significant physical functional impairment, and the procedure can be reasonably expected to improve the physical functional impairment. In addition, other medical criteria must be met for this procedure to be prior authorized, including:

- The Covered Person must be age 18 or older with growth complete;
- The Covered Person must have persistent symptoms in at least two anatomical body areas and affecting daily activities as defined by medical policy;
- The Covered Person must try other more conservative treatments; and
- The appropriate amounts in grams of breast tissue must be anticipated for removal.

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.

COVERED HEALTH SERVICES – Continued

40. REHABILITATION 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 limit does not include services as described under Autism Spectrum Disorder Services in this section.
- Speech therapy, limited to 20 visits per year. This limit 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 transluminal 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 36 visits per year must be performed by a Physician or by a licensed therapy Provider. Benefits under this section include 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.

41. SKILLED NURSING FACILITY

Covered Health Services includes 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) or in a private room where a semi-private room is not available.
- Ancillary services and supplies — services received during the Inpatient Confinement 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 Confinement in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

COVERED HEALTH SERVICES – Continued

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.

42. STERILIZATION SERVICES

Coverage includes Covered Health Services for the following sterilization services:

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

43. 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. Please check both **Section 6: Prior Authorization** and **Section 8: Exclusions and Limitations** to understand the requirements and limits on coverage for specific surgical benefits.

Benefits under this section include certain endoscopic procedures. 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 for medically necessary services.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for Physician services are described under Physician Fees for Surgical and Medical Services provision.

44. 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.

COVERED HEALTH SERVICES – Continued

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

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

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

45. 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.

46. TRANSFUSIONS/INFUSIONS

Coverage includes Covered Health Services for transfusions/infusions and must be for the treatment of a covered condition:

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

We may have programs in which you may receive an enhanced or reduced benefit based on the care setting you choose. Please contact us for more information.

47. 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 us at [877.514.2442] for information about these guidelines.

COVERED HEALTH SERVICES – Continued

48. URGENT CARE CENTER SERVICES

Benefits include Medically Necessary Covered Health Services received at an Urgent Care Center. If you are within our [20-county] service area, you must visit an In-Network Urgent Care Center for Benefits to apply. Outside of our [20-county] service area, you may visit an Out-of-Network Urgent Care Center or an Out-of-Network Provider for Urgent Care services, but we will pay our Maximum Allowed Amount toward the services which may be less than the facility's or provider's billed charges.

49. URINARY CATHETERS (INTERMITTENT AND INDWELLING)

Coverage includes Covered Health Service for intermittent and indwelling urinary catheters 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.

50. VISION EXAMINATIONS

Coverage includes Covered Health Services 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 Covered Persons through age 18)
 - Contact lenses
- Basic frames are covered once every 12 months

NOTE: If a Covered child receives 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 8: 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 7: 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. 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 Policy:

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 Policy.

- 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.

EXCLUSIONS AND LIMITATIONS *continued*

- 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.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- 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.
- Treatments for the primary diagnosis 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 us. 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 Policy:

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 7: 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. 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.
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, Oral Surgery and Temporomandibular Joint Disorder Services in **Section 7: 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 surgery performed only to improve appearance.

EXCLUSIONS AND LIMITATIONS *continued*

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 7: Covered Health Services**.

D. DEVICES, APPLIANCES AND PROSTHETICS

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

- Devices used specifically as safety items or to affect performance in sports-related activities.
- 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.
- The following items, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
- 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 7: Covered Health Services**.
- Oral appliances for snoring.
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect
- Replacement of lost or stolen items.
- Wearable robotic exoskeleton systems.

E. EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

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

Experimental or Investigational and Unproven Services and all services related to or complications resulting from Experimental or Investigational and Unproven Services. 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 pharmacy services are Experimental, Investigational and Unproven Services is made by us in consultation with a Pharmacy and Therapeutics review panel consisting of national experts with specialties matching the pharmaceuticals requested. For medical services, we use peer reviewed medical literature with emphasis on articles applying prospective randomized controlled trials to the services requested. When such publications are not available, we contact national specialty societies for their position statements on requested services, and we also use well researched national practice guidelines. When we receive a request for an Experimental, Investigational, or Unproven Service, we will issue a Benefit decision within 14 days of receipt. If we determine 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.

EXCLUSIONS AND LIMITATIONS continued

F. FOOT CARE

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

- Routine foot care is excluded other than painful plantar warts. Examples of non-Covered Services include the cutting or removal of corns and calluses, painful or otherwise, toenail fungus, 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 7: Covered Health Services**
- Nail trimming, cutting, or debriding
- 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
- Treatment of flat feet or arch supports
- Treatment of subluxation of the foot
- Shoes. Shoe inserts and shoe orthotics

G. MATERNITY SERVICES

The following services are not covered under this Policy:

- Elective abortions, except when performed to save the life/health of the mother and in instances of rape or incest.
- Home or intentional out of Hospital deliveries.
- Amniocentesis or Chorionic Villi Sampling (CVS) performed exclusively for sex determination.
- Birthing classes.
- 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 Policy

- Non-prescribed medical supplies, which include but are not limited to:
 - Compression stockings and/or elastic stockings. We will only cover compression stockings if Medically Necessary, prescribed by an In-Network Provider and obtained through an In-Network DME provider.
- Over the counter medical supplies, which include but are not limited to:
 - Bandage
 - Gauze and dressings
 - Antibiotic and anti-itch creams

EXCLUSIONS AND LIMITATIONS *continued*

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 7: Covered Health Services**.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in **Section 7: Covered Health Services**.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies **Section 7: Covered Health Services**.
- Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in **Section 7: Covered Health Services**.
- 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 7: Covered Health Services**, or any equipment required to be covered as a Preventive Service in **Section 7: Covered Health Services**.

I. MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

MENTAL HEALTH

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- 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 Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective
- 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
- 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 us
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- 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 7: Covered Health Services**
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. This exclusion does not apply for Mental Health Services provided as the result of an Emergency detention, commitment or court order

EXCLUSIONS AND LIMITATIONS *continued*

- Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, 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 our level of care guidelines/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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- 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.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by us. This exclusion does not apply to services provided as the result of an Emergency detention, commitment or court order
- Room and Board at Transitional Care Facilities
- Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in our reasonable judgment, 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 our 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 Policy except as described as Covered Services under the diabetes section:

- Individual and group nutritional counseling. This exclusion does not apply to any counseling required to be covered as a Preventive Service in **Section 7: 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 intervention of a trained health professional.

EXCLUSIONS AND LIMITATIONS *continued*

- Enteral feedings, even if the sole source of nutrition.
- Infant formula and donor breast milk.
- 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 Policy:

- Television.
- Telephone.
- Beauty/barber service.
- Guest service.
- Supplies, equipment and similar incidental services and supplies for personal comfort.

Examples include:

- Air conditioners, air purifiers and filters and dehumidifiers.
- Batteries and batterychargers.
- Breast pumps, except when required to be covered as a Preventive Service in **Section 7: 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.
- Heaters, heating lamps, heating pads.
- 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.
- Jacuzzis.
- Massage equipment, beds, and chairs.
- Mattresses.
- Medical alert- jewelry and phone systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Light fixtures, lightboxes or sun lamps for treatment of Seasonal Affective Disorders or other medical uses. Phototherapy provided for medically necessary treatment of certain skin disorders is a Covered Service as described in **Section 7: Covered Services**.
- Pillows.
- Power-operated vehicles and its accessories.
- Radios.
- Saunas.

EXCLUSIONS AND LIMITATIONS *continued*

- Scales.
- Stair lifts and stairglides.
- Step stools and standing tables.
- Strollers.
- Safety equipment.
- Special toilet seats and accessories
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools

L. PRESCRIPTION AND NON-PRESCRIPTION DRUGS

The **Section 9: Outpatient Prescription Drugs** section of this document explains how prescription medications are covered under this policy. The following services are not Covered Health Services under the Prescription Drug Benefits of this Policy:

- Over the counter medications, food, food supplements, vitamins and other nutritional and over-the-counter electrolyte supplements, except as described in **Section 7: Covered Services**.
- Prescription Drug Products for the amount dispensed (days, supply or quantity limit) which exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- 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.
- 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.
- Charges for drugs that are not listed in a Drug List.
- Charges for any amount over the Maximum Allowed Amount.
- 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 **Section 9: Outpatient Prescription Drug Benefits** section before they are dispensed.
- 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.
- Any product dispensed for appetite suppression or weight loss.

EXCLUSIONS AND LIMITATIONS continued

- Durable Medical Equipment covered under the Medical Benefits for Covered Health Services.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- 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.
- 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.
- Prescription Drug Products when prescribed to treat infertility.
- 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.
- 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.
- New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by us.
- Growth hormone therapy unless prescribed for Classic Growth Hormone Deficiency, Turner's syndrome, or certain other diagnoses as determined by CGHC and authorized in accordance with applicable policy and procedure, including evidence of growth hormone deficiency.
- 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.
- 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.
- 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.
- 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. CGHC will not accept drug manufacturer's coupons or financial assistance programs on select high cost specialty medications that have lower-cost options.
- Prescription Drug Products administered 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.
- 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; and prevention or treatment of excessive hair growth or abnormal hair patterns. Medically Necessary anabolic steroids are a covered expense.
- 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

EXCLUSIONS AND LIMITATIONS *continued*

- improvement or cognitive enhancement; daytime drowsiness (unless medical criteria is met); dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).
- Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition.
- 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.
- Charges for: postage, handling and shipping charges for any drugs.
- Charges for drugs for which Prior Authorization is required by us and is not obtained.
- 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.
- 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.

L. PHYSICAL APPEARANCE

Cosmetic Procedures are not Covered Health Services under this Policy. See the definition in **Section 4: Terms and 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.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spiderveins.
- Hair removal or replacement.
- Removal of skin tags, warts and other benign skin lesions with the exception of painful plantar warts.
- 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 7: Covered Health Services**.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
- Weight loss programs for any reason whether or not they are under medical supervision.
- Wigs for hair loss or any other reason.
- Botox (Botulinum toxin) as a treatment of skin wrinkles or other cosmetic indications.

EXCLUSIONS AND LIMITATIONS *continued*

M. PROCEDURES AND TREATMENTS

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

- Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty;
- Medical and surgical treatment of excessive sweating (hyperhidrosis);
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. A sleep study is required for documentation;
- 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;
- 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;
- Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post- traumatic brain Injury or cerebral vascular accident;
- Psychosurgery;
- Gender reassignment operations and related services;
- 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;
- Biofeedback except covered items in **Section 7: Covered Health Benefits**;
- 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;
- Surgical and non-surgical treatment of obesity;
- 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;
- Breast reduction that is not deemed medically necessary and does not meet our medical policies for prior authorization.

N. PROVIDERS

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

- 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
- Services performed by a Provider with your same legal residence.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a qualified in-Network Practitioner are not covered. Services which are self-directed to a free-standing or Hospital- based diagnostic facility are not covered. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility are not covered, 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 Policy:

- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- Surrogate parenting, including Maternity Services and any other treatment, services or supplies for a Covered Person's surrogate, sperm or other insemination, donor eggs, donor sperm and host uterus. This Exclusion does not apply only to those Maternity Services otherwise payable under this Policy for a Covered Person's Pregnancy while the Covered Person is serving as a surrogate host/gestational carrier
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- The reversal of voluntary sterilization and related procedures.
- In vitro fertilization regardless of the reason for treatment.

P. SERVICES PROVIDED UNDER ANOTHER PLAN

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

- 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.
- Health services paid for by other insurance or medical coverage, including but not limited to health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

Q. TRANSPLANTS

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

- Health services for organ and tissue transplants and all related expenses, except those described under Transplantation Services in **Section 7: Covered Health Services**
- Services and supplies in connection with transplants unless prior authorized by us
- 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 this Policy.)
- Any experimental or investigational transplant, or any other transplant-like technology not listed in this 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
- Health services for transplants involving permanent mechanical, artificial or animal organs.
- Donor costs, except cost directly related to organ removal from the donor.

EXCLUSIONS AND LIMITATIONS *continued*

R. TRAVEL

The following services are not Covered Health Services under this Policy

- Health services provided in a foreign country, unless required as Emergency Health Services. These Emergent Health Services do NOT include transportation expenses necessary to return you to the United States.
- 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 Benefits provided as described under Ambulance Services in **Section 7: Covered Health Services**.
-

S. TYPES OF CARE

The following services are not Covered Health Services under this Policy

- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
- Custodial Care or maintenance care or therapy.
- Domiciliary care.
- Private Duty Nursing.
- 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 7: Covered Health Services**.
- Rest cures.
- Services of personal care attendants.
- 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 Policy

- Purchase cost and fitting charge for eyeglasses and contact lenses.
- Implantable lenses used only to correct a refractive error (such as Intacs corneal implants except where used for the treatment of keratoconus).
- Eye exercise or vision therapy.
- Adult eye exams without eye disease or a specific diagnosis.
- 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.
- Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

EXCLUSIONS AND LIMITATIONS *continued*

- 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 Policy

- Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in **Section 4: Terms and Definitions**.
- Health services provided by Out-of-Network Providers or at Out-of-Network facilities except under the Limited Covered Health Services from Out-of-Network Providers provision.
- Health services provided by Out-of-Network Providers or at Out-of-Network facilities for which you did not comply with the Referral Process and gain approval from CGHC.
- Any follow-up care related to an Urgent or Emergency care service if received from a Out-of-Network Provider.
- Urgent Care Services received by a Out-of-Network Provider located in the Service Area.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this 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 7: Covered Health Services**.
 - Required to obtain or maintain a license of any type.
- 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.
- Health services received before your Effective Date or after the date your coverage under this 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.
- 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 this Policy, or for which a Provider, pharmaceutical manufacturer or similar entity pays a portion of the charge. This includes any financial assistance including coupons, savings cards, grants, special programs or gift/cash cards you may receive. Such amounts will not be credited to your Deductible, Coinsurance or Maximum-Out-Of-Pocket limit.
- Health services for which billing is not received by us within 15 months of the date of service.
- In the event a Out-of-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.
- Charges in excess of Eligible Expenses or in excess of any specified limitation, including the Maximum Allowed Amount.

- 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.
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
- Autopsy
- Dry needling, prolotherapy
- Coma Stimulation programs
- Court ordered care, unless medically necessary and otherwise covered under this Certificate
- Foreign language and sign language services in a clinical setting including a medical provider's office or other facility. Reasonable foreign language and sign language services will be provided by CGHC when needed to communicate with members regarding benefits.

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 or Experimental Procedure.

SECTION 9: OUPATIENT PRESCRIPTION DRUG INFORMATION

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. You should refer to the Outpatient Prescription Drug section of your Schedule of Benefits to better understand your coverage, as well as our prescription drug list, otherwise known as our Formulary, which can be found by click the Prescription Coverage button on www.CommonGroundHealthCare.org

Prescription drug exclusions from coverage are listed in **Section 8: Exclusions and Limitations**.

COVERAGE POLICIES AND GUIDELINES

Prescribed medications, or Pharmaceutical Products, are assigned to various tiers. The Plan makes the final classification of a Pharmaceutical Product to a certain tier by considering several 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.

A "formulary" is a document that explains what tier Pharmaceutical Products are assigned to, and whether there are any other limitations on the medications including prior authorization requirements, quantity limits, step therapy requirements and so on. To determine the tiers to which Pharmaceutical Products are assigned, review the current CGHC Formulary by click on the Prescription Coverage button at www.CommonGroundHealthCare.org or call the Pharmacy Benefit Member Services telephone number at [855-577-6545] which is also listed on the back of 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 by reviewing clicking the Prescription Coverage button and reviewing the formulary at www.CommonGroundHealthCare.org or by calling [855-577-6545].

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 [855-577-6545]. 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.

OUPATIENT PRESCRIPTION DRUG INFORMATION - Continued

COVERAGE UNDER THIS POLICY IS LIMITED TO NETWORK PHARMACIES/DESIGNATED PHARMACIES

Benefits are provided for Prescription Drug Products dispensed by retail In-Network Pharmacies and Covered Medications must be obtained through an In-Network or Designated (see next section) Pharmacy. Network Pharmacies have agreed to accept discounted payment for Covered Health Services subject to Copayment, Coinsurance and Deductible amounts. You may be billed by your Network Pharmacy for any non-Covered Health Services you receive or when you have not acted in accordance with this Policy.

There is no coverage for Covered Health Services provided by Out-of-Network Pharmacies. You will be fully responsible for payment of medications obtained from Out-of-Network Pharmacies. You may obtain further information about the status of In-Network pharmacies by calling our Member Services department at [877.514.2442] or by clicking on the “Prescription Coverage” button located on our website home page at www.CommonGroundHealthCare.org.

DESIGNATED PHARMACIES/SPECIALTY MEDICATIONS

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, your prescription will not be covered. Please see **Section 4: Terms and Definitions** for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

PRESCRIPTION DRUG PRODUCTS FROM A MAIL ORDER NETWORK PHARMACY

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. Please access www.CommonGroundHealthCare.org 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.

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, but 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 available for prescriptions filled at a Out-of-Network Pharmacy. However, in the event of an emergency, we will pay the Maximum Allowed Amount.

REBATES AND OTHER PAYMENTS

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates directly on to you, nor are they taken into account in determining your Deductible, Copayments and/or Coinsurance.

SECTION 10: 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 when you or another Covered Person have Benefits under any other Policy or Plan that provides Coverage or services for medical, pharmacy or dental care or treatment to a Covered Person. 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.

TERMS AND DEFINITIONS SPECIFIC TO THIS SECTION

PRIMARY PLAN: When you or another Covered Person have more than one Policy or Plan, the plan that is required to pay first is called a Primary Plan.

- A Primary Plan may include: 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.
- A Primary 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.

Any policy that falls under either bullet above is a separate Plan. If a Plan has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate Plan. You must notify us if you have any other coverage that constitutes a Plan under any other Policy or Plan that provides Coverage or Services for medical, pharmacy or dental care or treatment to a Covered Person.

ALLOWABLE EXPENSE: A health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Primary Plan and your CGHC policy. 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:

- 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.
- 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.
- 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.

COORDINATION OF BENEFITS - Continued

- If the Primary Plan calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, the Primary Plan's payment arrangement shall be the Allowable Expense for both plans.
- 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.

CLOSED PANEL PLAN: 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.

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

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical Benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-Network Benefits.

- A Plan may consider the Benefits paid or provided by another Plan in determining its Benefits only when it is secondary to that other Plan.
- Each Plan determines its order of Benefits using the first of the following rules that apply:
 - 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.

COORDINATION OF BENEFITS - Continued

- Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a Dependent child shall determine the order of Benefits as follows:
 - a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - ii. 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:
 - i. 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
 - ii. 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) shall determine the order of benefits
 - iii. 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) shall determine the order of benefits
 - iv. 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:
 - 1. The Plan covering the Custodial Parent
 - 2. The Plan Covering the Custodial Parent's Spouse
 - 3. The Plan covering the non-Custodial Parent
 - 4. 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.
- 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.

COORDINATION OF BENEFITS - Continued

- 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.
- 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.
- 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

We may reduce Benefits under the provisions of this Certificate so that the total Benefits paid or provided by all plans are not more than the total Allowable Expenses. If we are the Secondary Plan, we will calculate the Benefits we would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. We may then reduce our payment by an 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.

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.

COORDINATION OF BENEFIT PROVISIONS IMPACTING THOSE ELIGIBLE FOR MEDICARE

CGHC reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan. If your Employer or Enrolling Group has 19 or fewer employees, Medicare is likely to be the primary payer. If your Employer or Enrolling Group has 20 or more employees, Medicare is likely to be the secondary payer. You may wish to contact 1-800-Medicare to inquire about your coverage.

If a Covered Person has other health insurance which is determined to be primary to Medicare, then Benefits will be based on Medicare's reduced Benefits. In no event will the combined Benefits paid under your CGHC policy exceed the total Medicare Eligible Expense for the service or item.

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 was covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-Covered Health 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.

COORDINATION OF BENEFITS - Continued

- 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.

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, 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.

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 to apply these rules and determine 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 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.

SECTION 11: GENERAL LEGAL PROVISIONS

YOUR RELATIONSHIP WITH US

To make choices about your health care coverage and treatment, we believe that it is important for you to understand how your policy works. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether your Policy 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.
- This Policy may not pay for all treatments you or your Physician may believe are necessary. If this Policy does not pay, you may 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 enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage), timely payment of the Policy Premium to us, and 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 the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy. 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 Service.
- You must decide if any Provider treating you is right for you. This includes Providers you choose and Providers to whom you have been referred.

GENERAL LEGAL PROVISIONS – Continued

- 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.

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

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

GENERAL LEGAL PROVISIONS – Continued

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 this Policy.

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

GENERAL LEGAL PROVISIONS – Continued

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.

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. Regarding 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.

SECOND OPINION AND MEDICAL EXAMINATION OF COVERED PERSONS

One second opinion per injury or illness by a Network Provider is covered regarding Covered Health Services. Prior Authorization for the second opinion must be obtained when it is required as described in **Section 6: Prior Authorization**. A referral is required if an Out-of-Network second opinion is requested from an Out-of-Network provider. 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 your CGHC 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 10: 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.

GENERAL LEGAL PROVISIONS – Continued

SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as "third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents consent before releasing any party from liability or payment of medical expenses.
- That 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 attorneys' fees to the attorney hired by you to pursue your damage/personal Injury claim.
- That after you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That Benefits paid by us may also be considered to be Benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an Injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That 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.

GENERAL LEGAL PROVISIONS – Continued

- That you will assign to us all rights of recovery against third Parties, to the extent of the reasonable value of services and *Benefits* we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

REFUND OF OVERPAYMENTS

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

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 Appeal/Grievances and Independent External Review Request provision 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

This Policy issued to the Subscriber, including this Certificate, the Application, the Schedule of Benefits, and any Riders and/or Amendments, constitutes the entire Policy.

SECTION 12: APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW

COMPLAINTS

A **COMPLAINT** is a verbal expression of dissatisfaction with us or any Network Provider. If you have a complaint, please contact the Member Services Department shown on your ID card. A Member Services representative will work with you to try to resolve your complaint 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

A **GRIEVANCE** is any written complaint or dispute expressing dissatisfaction with any aspect of CGHC 's operations or activities or that of any Network Provider. A Grievance could include written complaints regarding the provision of services, billing, concerns related to equity or discrimination, fraud waste and abuse, Privacy/HIPAA violations and many other things.

When you or an authorized representative asks us in writing to review any Adverse Benefit Determination, it is called an **APPEAL**.

You, or your authorized representative, may file an Appeal or Grievance with us within three 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 a scheduled meeting of CGHC's Member Appeal and Grievance Committee. You will be advised of your right to submit written comments, documents, or other information regarding your Appeal, your right to appear before the committee and/or be assisted or represented by the another person of your choice, the availability of interpreter services and how to contact us for scheduling or more information.

No fewer than seven 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.

APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW - Continued

EXPEDITED APPEAL/GRIEVANCE REQUEST

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

- 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; based on a prudent layperson's judgment or
- In the opinion of a Qualified Practitioner with knowledge of your medical condition determines that the appeal should be treated as an expedited appeal, or
- If the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you have received services but have not been discharged from the facility and you or your designee have filed a request for an Expedited Independent External Review.

Once we receive all the information we need to make a determination, an expedited request will be resolved as soon as possible but no later than 72 hours after receipt of the request.

INDEPENDENT EXTERNAL REVIEW PROGRAM

When we have denied an Appeal and you have exhausted the Appeals/Grievance process (outlined above), an Independent External Review is available to you within four months after we send you the final notice of Adverse Benefit Determination. To qualify for Independent External Review process, your situation or issue must involve an Adverse Benefit Determination based on the following:

- Medical judgment (for example: medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or experimental and investigational treatments); or
- Our denial of your request for Out-of-Network services when you believe that the clinical expertise of the out-of-plan Out-of-Network provider is medically necessary (but only if the treatment or service would otherwise be a covered benefit under your plan), or
- A rescission of your coverage (whether or not the rescission has any effect on any particular benefit at that time).

In most cases, you must have completed the Appeal/Grievance process prior to requesting an Independent External Review. Exceptions are:

- Both we and you agree that the matter may proceed directly to Independent External Review; or 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; or
- 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.

APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW - Continued

You may not request an Independent External Review if 1) the requested treatment is not a Covered Service under this Certificate; or 2) the decision involves contractual or legal interpretation without any use of medical judgment; or 3) for administration issues such as the application of amounts to your deductible.

HOW 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 after 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 include your name, address, and phone number, the reason you disagree with our decision, including any documents that support your position. Please include a statement authorizing your representative to pursue Independent External Review on your behalf if you choose to use one.

HOW TO FILE AN EXPEDITED INDEPENDENT EXTERNAL REVIEW

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

- 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
- 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 provided in writing within forty-eight (48) hours.

APPEALS, GRIEVANCES AND INDEPENDENT EXTERNAL REVIEW - Continued

THE INDEPENDENT REVIEW PROCESS

Once you make a qualified request for Independent External Review, you will be assigned an Independent Review Organization (IRO) that 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.

Decisions of the IRO, either through regular or expedited review, are final and binding unless the decision is regarding rescission.

OFFICE OF THE COMMISSIONER OF INSURANCE

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

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

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