Golden Rule®

A UnitedHealthcare Company

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719
For Inquiries: (800) 657-8205

In this *policy*, *"you"* or *"your"* will refer to the Insured named on page 3, and *"we," "our,"* or *"us"* will refer to Golden Rule Insurance Company, a stock company.

MEDICAL EXPENSE INSURANCE POLICY

Section 1

AGREEMENT AND CONSIDERATION: *We* will pay benefits for a *loss* as set forth in this *policy*. This *policy* is issued in exchange for and on the basis of the statements made on *your* application and payment of the first premium. It takes effect on the *effective date* shown in the Data Page. It will remain in force until the first premium due date, and for such further periods for which premium payment is received by *us* when due, subject to the renewal provision below. All periods will begin and end at 12:01 A.M., Standard Time, where *you* live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS: *You* may keep this *policy* in force by timely payment of the required premiums. This *policy* will renew on January 1 of each calendar year. However, *we* may refuse renewal if: (A) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live, as explained under the Discontinuance clause; or (B) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

On January 1 of each calendar year, *we* may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. Some of the factors used in determining *your* premium rates are the policy plan, tobacco use status, type and level of benefits, place of *residence* on the premium due date, and age of *covered persons* as of the *effective date* or renewal date of coverage.

At least 60 days notice of any plan to take an action or make a change permitted by this clause will be mailed to *you* at *your* last address as shown in *our* records.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY: Please read this *policy*. If *you* are not satisfied, *you* may notify *us* within 10 days after *you* received it. Any premium paid will be refunded, less claims paid. This *policy* will then be void from its start.

Check the attached application or enrollment form, if any. If it is not complete or has an error, please let *us* know. An intentional misrepresentation of a material fact or a fraudulent misstatement in the application or enrollment form may cause *your policy* to be voided, or a claim to be reduced or denied.

This *policy* is signed for *us* as of the *effective date* as shown in the Data Page.

President

***Your* coverage under this *policy* is renewable, subject only to the two conditions set forth in the renewal clause above. *We* have the right to change premiums as set forth above. See the Continuing Eligibility and Termination sections for reasons for *policy* termination, including moving to a new *network service area*.**

As a cost containment feature, this *policy* contains prior authorization requirements. Benefits are reduced or denied if the requirements are not met. Please refer to the Data Page and the Prior Authorization section.

Table of Contents

Section

1	**Policy Face Page**
2	**Data Page**
3	**General Definitions**
4	**Premiums**
5	**Dependent Coverage**
6	**Amount Payable**
7	**Medical Benefits**
8	**Prior Authorization**
9	**General Exclusions and Limitations**
10	**Continuing Eligibility**
11	**Termination**
12	**Claims**
	COORDINATION OF BENEFITS
13	**General Provisions**

Important Notice

This *policy* is a legal contract between *you* and *us*.

READ *YOUR POLICY* CAREFULLY.

Section 2

Data Page

Policy Number - [999-999-999]
Insured - [John Doe]
Total Premium - [$XXXX.XX]

Premium Mode - [Monthly/Quarterly]
Effective Date - [Month Day, Year]

IMPORTANT:

If *covered expenses* are incurred at a non-*network provider*, benefits will be less than the amount which would have otherwise been payable at a *network provider*. *Network providers* have agreed to discounted pricing for *covered expenses* with no additional billing to *you* other than *deductible amounts*, *copayment amounts*, and coinsurance. Non-*network providers* may bill *you* for any amount up to the billed charge.

DEDUCTIBLE AMOUNT, per calendar year

Network Provider

Per Person.. $6,500
Per Family.. $13,000

Non-Network Provider (including *covered expenses* credited to the *network provider deductible amount*)

Per Person.. $13,000
Per Family.. $26,000

Your deductible amount is likely to increase each year. If *you* have chosen the maximum *deductible amount*, the increase will be based on the cost-of-living adjustment (COLA) levels set annually by the Internal Revenue Service (IRS) with regard to the maximum deduction allowed by law for Health Savings Accounts (HSAs). If *you* have chosen a lower *deductible amount*, the increase will be based on COLA levels set annually by the IRS for the minimum deductible required of an HSA high deductible health plan. The increase is currently calculated as a percentage rounded to the nearest $50. All *deductible amounts* may be adjusted, even if not required to maintain tax-qualified status.

COINSURANCE PERCENTAGE

For *eligible expenses* in excess of the applicable *deductible amount*.................... 100%

NON-NETWORK PROVIDER BENEFITS*

Covered expenses do not include amounts in excess of the *eligible expense*. Non-*emergency* non-*network eligible expenses* will be reduced by 25% before application of any applicable *deductible amounts* and coinsurance provisions. This means, for example, $100 of non-*network eligible expenses* will be considered as $75 in *eligible expenses* for purposes of determining benefits. These reduced non-*network eligible expenses* will then be subject to any applicable *deductible amounts* and coinsurance provisions.

*Does not apply to pediatric dental [or vision] benefits.

NETWORK OUT-OF-POCKET MAXIMUM, per calendar year

Per Covered Person.. $6,500
Per Family.. $13,000

The out-of-pocket maximum includes all *deductible amounts*, *copayment amounts*, and coinsurance amounts applied to *covered expenses* incurred at *network providers* and to *covered expenses* incurred due to an *emergency* at non-*network providers*.

PRESCRIPTION DRUGS

You can access the UnitedHealthcare Prescription Drug List via *our* website or by calling the telephone number on *your* identification card. *We* have a process for evaluating benefits for a *prescription drug* that is not included in the Prescription Drug List but that has been prescribed as a *medically necessary* and appropriate alternative. For information about this process, call the telephone number on *your* identification card. Also see the Prescription Drug benefit provision in the Medical Benefits section of this *policy*.

This policy is intended to be and will be administered to qualify as a high deductible health plan for purposes of tax qualified Health Savings Account plans.

PRIOR AUTHORIZATION REQUIREMENTS

We require prior authorization for certain *covered expenses.* In general, when services or supplies are received from a *network provider,* the *network provider* is responsible for obtaining the prior authorization. When services or supplies are received from a non-*network provider, you* are responsible for obtaining the prior authorization. However, there are exceptions. Services and supplies for which *you* are responsible for obtaining prior authorization are listed below.

Failure to obtain prior authorization will result in a reduction or denial of benefits, as shown below. Failure to obtain prior authorization for pediatric orthodontic services may result in denial of the claim.

Obtaining prior authorization does not guarantee payment. Please see the Prior Authorization section for more information.

SERVICES AND SUPPLIES FOR WHICH YOU MUST OBTAIN PRIOR AUTHORIZATION

[**Ambulance, non-emergency**

You must obtain authorization for non-*emergency* ambulance transportation as soon as possible prior to transport. If *you* fail to obtain prior authorization, no benefits will be payable.

Autism Spectrum Disorder

For non-*network* benefits for *inpatient* services, *you* must obtain prior authorization before a scheduled admission, including an admission for partial hospitalization/day treatment and services at a *residential treatment facility;* or as soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions.

For non-*network* benefits for *outpatient* services, *you* must obtain prior authorization before receiving the following services: intensive *outpatient* treatment programs; psychological testing; applied behavior analysis; or extended *outpatient* treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Clinical Trials

You must obtain prior authorization as soon as the possibility of participation in a *clinical trial* arises. If *you* fail to obtain prior authorization, no benefits will be payable.

Diabetes Services

For non-*network* benefits, *you* must obtain prior authorization before obtaining any equipment, for the management and treatment of diabetes, that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If *you* fail to obtain prior authorization, no benefits will be payable.

Durable Medical Equipment

For non-*network* benefits, *you* must obtain prior authorization before obtaining any *durable medical equipment* that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If *you* fail to obtain prior authorization, no benefits will be payable.

Genetic Testing - BRCA

For non-*network* benefits, *you* must obtain prior authorization as soon as reasonably possible before BRCA genetic testing is performed. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Home Health Care

For non-*network* benefits, *you* must obtain prior authorization 5 business days before receiving *home health care* services, or as soon as reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Hospice Care - Inpatient

For non-*network* benefits, *you* must obtain prior authorization 5 business days before admission for an *inpatient* stay, or as soon as reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Hospital Inpatient Stay

For non-*network* benefits, *you* must obtain prior authorization 5 business days before a scheduled admission; or as soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Infertility Services

You must obtain prior authorization as soon as possible prior to receiving infertility services. If *you* fail to obtain prior authorization, no benefits will be payable.

Lab, X-Ray, and Diagnostics - Outpatient

For non-*network* benefits for sleep studies, stress echocardiography, and transthoracic echocardiogram, *you* must obtain prior authorization 5 business days before scheduled services are received. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Lab, X-Ray, and Major Diagnostics - CT, PET, MRI, MRA, Capsule Endoscopy and Nuclear Medicine

For non-*network* benefits, *you* must obtain prior authorization 5 business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Mental Health Services

For non-*network* benefits for *inpatient* services, *you* must obtain prior authorization before a scheduled admission; or as soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions.

For non-*network* benefits for *outpatient* services, *you* must obtain prior authorization before receiving the following services: partial hospitalization/day treatment; intensive *outpatient* treatment programs; electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; or extended *outpatient* treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Obesity Surgery

You must obtain prior authorization 6 months prior to *surgery* or as soon as the possibility of obesity *surgery* arises. In addition, for non-*network* benefits, *you* must contact *us* 24 hours before admission for an *inpatient* stay. At the time *you* seek to obtain prior authorization for obesity *surgery*, *we* will discuss with *you* the health care and financial advantages of using the services of a *designated facility*. If *you* fail to obtain prior authorization, no benefits will be payable.

Outpatient Surgery

For non-*network* benefits for *outpatient surgery, you* must obtain prior authorization 5 business days before receiving scheduled services; or for non-scheduled services, within one business day or as soon as is reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Pediatric Orthodontic Services

You must obtain prior authorization for all pediatric orthodontic services 30 days before receiving treatment by calling the telephone number on *your* dental identification card. Failure to obtain prior authorization for pediatric orthodontic services may result in denial of the claim.

Pregnancy and Delivery

For non-*network* benefits, *you* must obtain prior authorization as soon as reasonably possible if the *inpatient* stay for the mother and/or the newborn will be more than 48 hours following a normal vaginal

delivery or more than 96 hours following a caesarean section delivery. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Prosthetic Devices

For non-*network* benefits, *you* must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If *you* fail to obtain prior authorization, no benefits will be payable.

Reconstructive Surgery

For non-*network* benefits for *outpatient surgery*, *you* must obtain prior authorization 5 business days before a scheduled *reconstructive surgery* is performed; or for a non-scheduled *reconstructive surgery*, within one business day or as soon as is reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Rehabilitation and Extended Care Facility Services

For non-*network* benefits for *outpatient rehabilitation therapy* services(physical therapy, speech therapy, and occupational therapy only), *you* must obtain prior authorization 5 business days before receiving those services, or as soon as is reasonably possible.

For non-*network* benefits for *inpatient rehabilitation* or confinement in an *extended care facility, you* must obtain prior authorization 5 business days before a scheduled admission; or as soon as is reasonably possible prior to a non-scheduled admission.

If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Substance Abuse Disorder Services

For non-*network* benefits for *inpatient* services, *you* must obtain prior authorization before a scheduled admission, including an admission for partial hospitalization/day treatment and services at a *residential treatment facility;* or as soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions.

For non-*network* benefits for *outpatient* services, *you* must obtain prior authorization before receiving the following services: intensive *outpatient* treatment programs; psychological testing; or extended *outpatient* treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Therapeutic Treatments

For non-*network* benefits, *you* must obtain prior authorization for dialysis, intensity modulated radiation therapy, or MR-guided focused ultrasound 5 business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible. If *you* fail to obtain prior authorization, benefits will be reduced to 50% of *eligible expenses*.

Transplants

For *network* and non-*network* benefits, *you* must obtain prior authorization as soon as the possibility of a transplant arises and before the time a pre-transplant evaluation is performed at a transplant center.

At the time *you* seek to obtain prior authorization for a transplant, *we* will discuss with *you* the health care and financial advantages of using the services of a *designated facility*.

If *you* fail to obtain prior authorization, no benefits will be payable.]

Section 3
GENERAL DEFINITIONS

In this *policy, italicized* words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy:*

"Coinsurance percentage" means the percentage of *covered expenses* that are payable by *us* after the *deductible amount* or *copayment amount* has been met, as applicable.

"Copayment amount" means the amount of *covered expenses* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Data Page), before benefits are payable for remaining *covered expenses* for that service under this *policy*.

"Cosmetic treatment" means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury, illness,* or congenital anomaly.

"Covered expense" means an expense that is:

A. Incurred while *your* or *your dependent's* insurance is in force under this *policy;*

B. Covered by a specific benefit provision of this *policy;* and

C. Not excluded anywhere in this *policy*.

"Covered person" means *you, your* lawful *spouse* and each *eligible child:*

A. Named in the application or enrollment form; or

B. Whom *we* agree in writing to add as a *covered person*.

"Custodial care" means care that is administered for assistance (rather than for training or education) of the patient in performing the activities of daily living. *Custodial care* also includes nonacute care for the comatose, semicomatose, paralyzed, or mentally incompetent patient.

"Deductible amount" means the amount of *eligible expenses,* shown in the Data Page, that must actually be incurred by each *covered person* during any calendar year before any benefits are payable, unless the family deductible has been met, if applicable. The *deductible amount* does not include any *copayment amount*.

A new *deductible amount* must be met each calendar year.

"Dental expenses" means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

"Dependent" means *your* lawful *spouse* and/or an *eligible child*.

"Designated facility" means a *network* facility that has entered into an agreement with *us*, or with an organization contracting on *our* behalf, to provide covered health services for the treatment of specified diseases or conditions. The fact that a *hospital* is a *network provider* does not mean that it is a *designated facility*.

"Doctor" means a duly licensed practitioner of the medical arts. With regard to medical services provided to a *covered person,* a *doctor* must be currently licensed by the state in which the services are provided, and the services must be provided within the scope of that license. With regard to consulting services provided to *us,* a *doctor* must be currently licensed by the state in which the consulting services are provided.

"Effective date" means the date a *covered person* becomes insured. The *effective date* is shown:

A. In the Data Page of this *policy* for initial *covered persons;* and

B. In the written notification from *us* confirming the addition of a new *covered person*.

"Eligible child" means *your* or *your spouse's* child, if that child is less than 26 years of age.

As used in this definition, "child" means:

A. A natural child;

B. A legally adopted child;

C. A child placed with *you* for adoption; or

D. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

"*Eligible expense*" means a *covered expense* as determined below:

A. For *network providers*: When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.

B. For non-*network providers:*

1. When a *covered expense* is received from a non-*network provider* as a result of an *emergency*, the *eligible expense* is a rate agreed upon by *us* and the non-*network provider* or a rate determined based upon the higher of:

   a. The median amount negotiated with *network providers* for the same service; or

   b. 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (*CMS*) for the same or similar services within the geographic market.

2. For non-*emergency covered expenses* received at a *network* facility from a non-*network* facility-based physician, the *eligible expense* is based on 110% of the published rates allowed by *CMS* for the same or similar service within the geographic market with the exception of the following:

   a. 50% of the published rates allowed by *CMS* for the same or similar laboratory service.

   b. 45% of the published rates allowed by *CMS* for the same or similar *durable medical equipment*, or *CMS* competitive bid rates.

   When a rate is not published by *CMS* for the service:

   a. A gap methodology will be applied that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the service. The relative value scale currently used is created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. *We* and OptumInsight are related companies through common ownership by UnitedHealth Group.

   b. For pharmaceutical products, gap methodologies are applied that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

   c. If a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under the *CMS* published rates or a gap methodology, the *eligible expense* is based on 50% of the provider's billed charge.

3. Except as provided under B.1 and B.2 above, when a *covered expense* is received from a non-*network provider,* the *eligible expense* is determined based on the first of the following rules that can be applied in the order shown below:

   a. The fee that has been negotiated with the provider; or

   b. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or

   c. The fee established based on rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us;* or

   d. A fee based on a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the service. The relative value scale currently used is created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. *We* and OptumInsight are related companies through common ownership by UnitedHealth Group:

      i. For pharmaceutical products, gap methodologies are applied

that are similar to the pricing methodology used by *CMS* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

ii. When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under the *CMS* published rates or a gap methodology, the *eligible expense* is based on 50% of the provider's billed charge.

e. The fee charged by the provider for the services; or

f. A fee schedule that *we* develop.

IMPORTANT NOTE: Except when the *eligible expense* is an amount negotiated with the provider, non-*network providers* and non-*network* facility-based physicians may bill *you* for any difference between the billed charges and the *eligible expense*.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the *covered person* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

"Experimental or investigational treatment" means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

A. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

B. An *unproven service*.

C. Subject to *USFDA* approval, and:

1. It does not have *USFDA* approval;

2. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

3. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:

   a. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

   b. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

   c. Not an *unproven service*; or

4. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer-reviewed medical literature to treat the medical condition of the *covered person*.

D. Experimental or investigational according to the provider's research protocols.

Items C and D above do not apply to phase III or IV *USFDA* clinical trials.

"Extended care facility" means an institution, or a distinct part of an institution, that:

A. Is licensed as a *hospital, extended care facility,* or *rehabilitation facility* by the state in which it operates;

B. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *doctor* and the direct supervision of a registered nurse;

C. Maintains a daily record on each patient;

D. Has an effective utilization review plan;

E. Provides each patient with a planned program of observation prescribed by a *doctor;* and

F. Provides each patient with active treatment of an *illness* or *injury,* in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

"Freestanding facility" means an *outpatient,* diagnostic, or ambulatory center, or independent laboratory that performs services and submits claims separately from a *hospital.*

"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.

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 medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under this *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

"Hospital" means an institution that:

A. Operates as a *hospital* pursuant to law;

B. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients;*

C. Provides 24-hour nursing service by registered nurses on duty or call;

D. Has staff of one or more *doctors* available at all times;

E. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and

F. Is not primarily a long-term care facility; an *extended care facility,* nursing, rest, *custodial care,* or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility, extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

"Illness" means a sickness, disease, disorder, or abnormal condition of a *covered person*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness,* the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

"Immediate family" means the parents, *spouse,* children, or siblings of any *covered person,* or any person residing with a *covered person*.

"Injury" means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

"Inpatient" means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

"Intensive care unit" means a Cardiac Care Unit, or other unit or area of a *hospital,* that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

"Loss" means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

"Medical practitioner" means a *doctor* or other health care provider licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification. With regard to consulting services provided to *us,* a *medical practitioner* must be licensed or certified by the state in which the consulting services are provided.

"Medically necessary" means a health care service or product that a prudent *doctor* would provide to a patient to prevent, diagnose, or treat an *illness*, *injury*, or disease, or any symptoms thereof, that are necessary and are:

A. Provided in accordance with generally accepted standards of medical practice;

B. Clinically appropriate with regard to type, frequency, extent, location, and duration;

C. Not provided mainly for the convenience of the *covered person*, physician, or other health care provider;

D. Required to improve a specific health condition of a *covered person* or to preserve his or her existing state of health; and

E. The most clinically appropriate level of health care that may be safely provided to a *covered person*.

"Mental disorder" means a mental or emotional disease or disorder that is:

A. A disease of the brain with predominant behavioral symptoms;

B. A disease of the mind or personality, evidenced by abnormal behavior; or

C. A disorder of conduct evidenced by socially deviant behavior.

Mental disorder includes psychiatric *illnesses* listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

"Network" means a group of *doctors* and providers who have contracts that include an agreed upon price for health care expenses that are *covered expenses* under this *policy*.

"Network provider" means a *doctor,* provider, or *member pharmacy* who is identified in the most current list for the *network* applicable to this *policy* and shown on *your* identification card.

"Network service area" means counties in Nevada in which *we* offer medical expense coverage under policies issued on this form and under which the services of *network providers* are available for the *network* shown on *your* health insurance identification card.

"Outpatient" means that medical services, supplies, or treatment are received by a *covered person* who is not receiving *inpatient* care in a *hospital* or medical facility. *Outpatient* does not include medical services, supplies, or treatment received by a *covered person* at home, school, or any other non-medical place of service, unless specifically covered in the home or school by this *policy*.

"Outpatient surgical facility" means any facility with a medical staff of doctors that operates pursuant to law for the purpose of performing *surgical procedures,* and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers,* ambulatory-care clinics, free-standing *emergency* facilities, and *doctor* offices.

"Policy" when italicized, means this *policy* issued and delivered to *you*. It includes the attached pages, the application(s) and/or enrollment form(s), if any, and any amendments.

"Primary care physician" means a *doctor* who is a family practitioner, general practitioner, pediatrician, or internist.

"Proof of loss" means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* repricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other insurance carrier, including Medicare.

"Residence" means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of *residence*. If *you* do not file a United States income tax return, the residence where *you* spend the greatest amount of time in a calendar year will be deemed to be *your* place of *residence*.

"Residential treatment facility" means a facility that provides (with or without charge) sleeping accommodations, and:

A. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or

B. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

"Specialist physician" means a *doctor* who is not a *primary care physician*.

"Spouse" means the person to whom *you* are legally married, or *your* domestic partner.

"Substance abuse" means alcohol, drug or chemical abuse, overuse, or dependency.

"Surgery" or *"surgical procedure"* means:

A. An invasive diagnostic procedure; or

B. The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *doctor* while the *covered person* is under general or local anesthesia.

"Unproven service(s)" means 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 *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

A. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, the patient is not allowed to choose which treatment is received, and neither the provider nor the patient is informed as to which treatment the patient is receiving.

B. *"Well-conducted cohort studies"* means 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.

"Urgent care center" means a facility, not including a *hospital emergency* room or a *doctor's* office, that provides treatment or services that are required:

A. To prevent serious deterioration of a *covered person's* health; and

B. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

Section 4
PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid by *you* without contribution or reimbursement by or on behalf of any health care provider or any health care provider sponsored organization. Each premium is to be received by *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

GRACE PERIOD: *You* have until the 31st day following each premium due date to pay all premiums due. *We* may pay benefits for *your covered expenses* incurred during this 31-day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from *you* by the end of the grace period.

However, if *we* pay benefits for any claims during the grace period, and the full premium is not paid by the end of the grace period, *we* will require repayment of all benefits paid from *you* or any other person or organization that received payment on those claims. If repayment is due from another person or organization, *you* agree to assist and cooperate with *us* in obtaining repayment. *You* are responsible for repaying *us* if *we* are unsuccessful in recovering our benefits from these other sources.

MISSTATEMENT OF AGE OR TOBACCO USE: If a *covered person's* age or tobacco use status has been misstated in the application or enrollment form, the premium payable under this *policy* shall be retroactively adjusted to be the premium that should have been paid based on the correct age or tobacco use status.

CHANGE OR MISSTATEMENT OF RESIDENCE: If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first premium due date after the change. If *your residence* is misstated on *your* application or enrollment form, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

BILLING/ADMINISTRATIVE FEES: *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Section 5
DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: *Your dependents* become eligible for insurance on the later of:

A. The date *you* became insured under this *policy;* or

B. The first day of the premium period after the date of becoming *your dependent*.

EFFECTIVE DATE FOR INITIAL DEPENDENTS: The *effective date* for *your* initial *dependents,* if any,

is shown in the Data Page. Only *dependents* who were covered as *your dependents* under previous medical coverage with *us* until the *effective date* of this coverage, or who were included as *your dependents* in the most current application or enrollment form for coverage with *us*, will be covered on *your effective date*.

ADDING A NEWBORN CHILD: An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until the 31st day after its birth, unless *you* or *your spouse* advises *us* not to add the newborn child. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness,* including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium may be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received both written notice of the child's birth and the required premium within 90 days of the child's birth.

ADDING AN ADOPTED CHILD: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness,* including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium may be required to continue coverage beyond the 31st day following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both written notice of *your* or *your spouse's* intent to adopt the child and the required premium within 90 days of the date of *placement*.

As used in this provision, *"placement"* means the earlier of:

A. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or

B. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

ADDING OTHER DEPENDENTS: If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

Section 6
AMOUNT PAYABLE

AMOUNT PAYABLE: A new *deductible amount* must be met each calendar year.

We will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount(s)* and *copayment amount(s)* for a service or supply that:

A. Qualifies as a *covered expense* under one or more benefit provisions; and

B. Is received while the *covered person's* insurance is in force under this *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the out-of-pocket maximum has been met, additional *covered expenses* incurred at *network providers* or due to an *emergency* at non-*network providers* will be payable at 100% of *eligible expenses*.

The amount payable will be subject to:

A. Any specific benefit limits stated in this *policy;*

B. A determination of *eligible expenses;* and

C. Any reduction for expenses incurred at a non-*network provider*. (Please refer to the information in the Data Page.)

The applicable *deductible amount(s), coinsurance percentage,* and *copayment amounts* are shown in the Data Page.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount,* copayment, and coinsurance, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will <u>not</u> apply to *your deductible amount* or maximum out-of-pocket expenses.

COVERAGE UNDER OTHER POLICY PROVISIONS: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy*.

CONTINUITY OF CARE: If a *covered person* is receiving medical treatment from a health care provider whose contract with *us* is terminated during the course of the medical treatment, the *covered person* may continue to obtain the medical treatment from the provider if:

A. The *covered person* is actively undergoing a *medically necessary* course of treatment; and

B. The health care provider and the *covered person* agree that continuity of care is desirable.

Coverage of the medical treatment will continue at the same rate of payment as before the provider's contract terminated until the later of:

A. The 120th day after the date the provider's contract terminated; or

B. For pregnancy, the 45th day after the date of delivery or the date of the end of the pregnancy if the pregnancy does not end in delivery.

The requirements of this Continuity of Care provision do not apply if *we* terminated the provider's contract because of medical incompetence or professional misconduct, and *we* did not enter into another contract with the provider after the provider's contract was terminated.

Section 7
NEVADA MEDICAL BENEFITS

Standard medical *covered expenses* are limited to charges for the services and supplies provided to a *covered person* and described in this section.

AMBULANCE SERVICES: *Covered expenses* include the charges incurred by a *covered person* for ambulance services to the nearest *hospital* that can provide services appropriate for the *covered person's illness* or *injury* when the *covered person* cannot be transported safely by other means.

We will directly reimburse a provider of medical transportation for *covered expenses* if that provider does not receive reimbursement from any other source.

Limitation: *Covered expenses* for air ambulance are limited to those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

AUTISM SPECTRUM DISORDERS: *Covered expenses* include the charges for screening for and diagnosis and treatment of *autism spectrum disorders* for *covered persons* less than 18 years of age and for *covered persons* 18 to 22 years of age if enrolled in high school.

Treatment of *autism spectrum disorders* must be identified in a treatment plan and may include *habilitative or rehabilitative care*, *prescription care*, psychiatric care, psychological care, *behavioral therapy*, or *therapeutic care* that is:

A. Prescribed for a *covered person* diagnosed with an *autism spectrum disorder* by a licensed physician or licensed psychologist; and

B. Provided by a licensed physician, licensed psychologist, licensed behavior analyst, or other provider that is supervised by the licensed physician, licensed psychologist, or licensed behavior analyst.

Limitations: *Covered expenses* for *applied behavioral analysis* are limited to 1,500 hours of therapy per *covered person* per calendar year.

Exclusion: *Covered expenses* do not include care provided by an early intervention agency or school for services delivered through early intervention or school services.

Definitions:

"*Applied behavior analysis*" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

"*Autism behavior interventionist*" means a person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of:

A. A license psychologist;

B. A licensed behavioral analyst; or

C. A licensed assistant behavior analyst.

"*Autism spectrum disorder*" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

"*Behavioral therapy*" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training, and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst, or *autism behavior interventionist*.

"*Habilitative or rehabilitative care*" means counseling, guidance, and professional services and treatment programs, including, without limitation, *applied behavior analysis*, that are necessary to develop, maintain, and restore, to the maximum extent feasible, the functioning of a *covered person*.

"*Prescription care*" means medications prescribed by a licensed physician and any health-related services deemed *medically necessary* to determine the need or effectiveness of the medications.

"*Therapeutic care*" means services provided by licensed or certified speech pathologists, occupational therapists, and physical therapists.

CATARACT SURGERY: *Covered expenses* include the charges incurred by a *covered person* after a cataract *surgery* for the following:

A. Services provided for the initial prescription for corrective lenses; and

B. 1 pair of eyeglasses or contact lenses, or intra-ocular lens implants.

Limitation: Benefits under this provision are limited to $100 for frames or contact lenses.

Exclusions: *Covered expenses* do not include:

A. Coated lenses.

B. Cosmetic contact lenses.

C. No-line bifocal or trifocal lenses.

D. Oversize lenses.

E. Plastic multi-focal lenses.

F. Tinted or photochromic lenses.

G. Two pairs of lenses and frames instead of bifocal lenses and frames.

H. Prescription sunglasses.

CLINICAL TRIALS: *Covered expenses* include charges incurred by a *covered person* for *routine patient care costs* incurred as a result of participation in a Phase I, II, III, or IV *clinical trial* for the prevention, early detection, and treatment of cancer or other *life-threatening conditions*.

Covered expenses also include the charges incurred by a *covered person* for medical treatment received as part of a *clinical trial* or study if all of the following conditions are met:

A. The medical treatment is provided in a Phase I, II, III, or IV study or *clinical trial* for the treatment of cancer or other life-threatening disease or condition or in a Phase II, III, or IV study or *clinical trial* for the treatment of chronic fatigue syndrome.

B. A Phase I, II, or III *clinical trial* for the treatment of the following diseases and disorders that are not life threatening, for which *we* determine a clinical trial meets the qualifying *clinical trial* criteria stated in this benefit provision:

    1. Cardiovascular disease (cardiac/stroke).

    2. Surgical musculoskeletal disorders of the spine, hip, and knees.

    3. Other disease or disorders.

C. In the case of a Phase I *clinical trial* study for the treatment of cancer, the medical treatment is provided at a *facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer*.

D. In the case of a Phase II, III, or IV study or *clinical trial* for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a *doctor* and the *facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer* and personnel for the *clinical trial* or study have the experience and training to provide the treatment in a capable manner.

E. There is no medical treatment available that is considered a more appropriate alternative medical treatment than the medical treatment provided in the *clinical trial* or study.

F. There is a reasonable expectation, based on clinical data, that the medical treatment provided in the *clinical trial* or study will be at least as effective as any other medical treatment.

G. The *clinical trial* or study is conducted in the state of Nevada.

H. The *covered person* has signed, before participation in the *clinical trial* or study, a statement of consent indicating that he or she has been informed of, without limitation:

   1. The procedure to be undertaken;

   2. Alternative methods of treatment; and

   3. The risks associated with participation in the *clinical trial* or study, including, without limitation, the general nature and extent of such risks.

Covered expenses for medical treatment received as part of a *clinical trial* or study meeting the conditions stated above are limited to:

A. Any drug or device that is approved for sale by the USFDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the *covered person*.

B. The cost of any *medically necessary* health care services that are required as a result of the medical treatment provided, or any complication arising out of the medical treatment provided, in a Phase II, III, or IV *clinical trial* or study, to the extent that such health care services would otherwise be covered under this *policy*.

C. The cost of any routine health care services that would otherwise be covered under this *policy* for the *covered person* participating in a Phase I *clinical trial* or study.

D. The initial consultation to determine whether the *covered person* is eligible to participate in the *clinical trial* or study.

E. Health care services required for the clinically appropriate monitoring of the *covered person* during a Phase II, III, or IV *clinical trial* study.

F. Health care services that are required for the clinically appropriate monitoring of the *covered person* during a Phase I *clinical trial* or study and that are not directly related to the *clinical trial* or study.

Exclusions: *Covered expenses* do not include the charges for:

A. Any incidental medical treatment provided free of charge during the *clinical trial* or study.

B. Any portion of the *clinical trial* or study that is customarily paid for by a government or a biotechnical distributor or provider of drugs or devices.

C. Drugs or devices that are paid for by the manufacturer, distributor, or provider of the drug or device.

D. Services that are specifically excluded from coverage under this *policy*, regardless of whether such services are provided under the *clinical trial* or study.

E. Services that are customarily provided by the sponsors of the *clinical trial* or study free of charge to the participants in the *clinical trial* or study.

F. Extraneous expenses related to participation in the *clinical trial* or study, including, without limitation, travel, housing, and other expenses that the *covered person* may incur.

G. Any expenses incurred by a person who accompanies the *covered person* to the *clinical trial* or study.

H. Items or services provided solely to satisfy data collection of analysis not directly related to the clinical management of the *covered person*.

I. Costs for the management of research relating to the *clinical trial* or study.

Definitions:

"Clinical trial" means a research study that:

A. Is approved or funded by one or more of the following:

   1. National Institutes of Health (NIH).

   2. Centers for Disease Control and Prevention (CDC).

   3. The Agency for Health Care Research and Quality (AHRQ).

   4. Centers for Medicare and Medicaid Services (CMS).

   5. A cooperative group or center of any of the entities listed above, or the Department of Defense (DOD) or the Veterans Administration (VA).

   6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy provides that the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to:

   a. Be comparable to the system of peer review studies used by the National Institutes of Health; and

   b. Ensure unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

B. Is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. Is a drug trial that is exempt from having such an investigational new drug application.

D. Has a written protocol that describes a scientifically sound study and has been approved by all relevant institutional review boards before participants are enrolled in the trial.

"Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate that meets all of the following conditions:

A. Has in place a Phase I program, which permits only selective participation in the program and uses clear-cut criteria to determine eligibility for participation in the program.

B. Operates a protocol review and monitoring system that conforms to the standards set forth in the policies and guidelines relating to the cancer center support grant published by the Cancer Centers Branch of the National Cancer Institute.

C. Employs at least two researchers and at least one of those researchers received funding from a federal grant.

D. Employs at least three clinical investigators who have experience working in Phase I *clinical trials* or studies conducted at a *facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer* designated as a comprehensive cancer center by the National Cancer Institute.

E. Possesses specialized resources for use in Phase I *clinical trials* or studies including, without limitation, equipment that facilitates research and analysis in proteomics, genomics, and pharmacokinetics.

F. Is capable of gathering, maintaining, and reporting electronic data.

G. Is capable of responding to audits instituted by federal and state agencies.

"Life-threatening condition" means a condition from which the likelihood of death is probable unless the course of the condition is interrupted.

"Routine patient care costs" means items and services that would be considered *covered expenses* if the *covered person* were not involved in a *clinical trial*. *Routine patient care costs* do not include:

A. The investigational item or service itself.

B. Items or services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the *covered person*.

C. A service or supply that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

CORRECTIVE APPLIANCES: *Covered expenses* include charges incurred by a *covered person* for custom-made or custom-fitted *medically necessary corrective appliances* including the following:

A. Rigid Cervical Collars;

B. Abdominal Binder/Corsets;

C. Shoes when prescribed for a diabetic condition, otherwise only when an integral part of a lower body brace; and

D. Helmets when prescribed in connection with cranial orthosis.

Corrective appliances do not include:

A. Bionic, myoelectric, microprocessor-controlled, and computerized prosthetic; or

B. Deluxe upgrades determined not to be *medically necessary*.

Covered expenses include charges incurred by a *covered person* for replacements, repairs and adjustments to *corrective appliances* when required by normal wear and tear or by a significant change in the *covered person's* condition when ordered by a *doctor*.

Definition:

"*Corrective appliances*" means devices that are designed to support a weakened body part and are manufactured or custom-fitted to an individual.

DENTAL ANESTHESIA: *Covered expenses* include the charges incurred by a *covered person* for general anesthesia and associated dental care procedures provided in a *hospital*, an *outpatient surgical facility*, an independent center for *emergency* care, or a rural clinic, to a covered *eligible child* who:

A. Has a physical, mental, or medically compromising condition;

B. Has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy;

C. Is extremely uncooperative, unmanageable, or anxious; or

D. Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

The general anesthesia must be performed by:

A. A qualified specialist in pediatric dentistry;

B. A dentist who is qualified by virtue of his/her education in a recognized dental specialty for which *hospital* privileges are granted; or

C. A dentist who is certified by a *hospital* by virtue of his completion of an accredited program of postgraduate *hospital* training and is granted *hospital* privileges.

DIABETES SERVICES: *Covered expenses* include the charges incurred by a *covered person* for the following for the treatment of Type I, Type II, or gestational diabetes:

A. Medication, equipment, supplies, and appliances; and

B. Self-management training and education that is:

   1. Provided upon the initial diagnosis of diabetes;

   2. Provided because of a significant change in the *covered person's* symptoms or condition; or

   3. Necessary as a result of the development of new techniques and treatment for diabetes.

DIAGNOSTIC SERVICES: *Covered expenses* include the charges incurred by a *covered person* for the following diagnostic services:

A. Diagnostic testing using laboratory services and ultrasonographic services.

B. Radiologic and non-radiologic imaging services and materials, including general radiography, fluoroscopy, mammography, and sonography.

C. Complex diagnostic imaging services, including nuclear medicine, computerized axial tomography (CT scan), cardiac ultrasonography, magnetic resonance imaging (MRI), and arthrography.

D. Complex vascular diagnostic services, including Holter monitoring, treadmill or stress testing, and impedance venous plethysmography.

E. Complex neurological diagnostic services, including electroencephalograms (EEG), electromyogram (EMG), and evoked potential.

F. Complex psychological diagnostic testing.

G. Complex pulmonary diagnostic services, including pulmonary function testing and apnea monitoring.

H. Complex allergy diagnostic services, including RAST and allergoimmuno therapy.

I. Otologic evaluations.

J. Positron Emission Tomography (PET) scans.

Psychometric, behavioral and educational testing are not included.

DURABLE MEDICAL EQUIPMENT: *Covered expenses* include the charges incurred by a *covered person* for the following *durable medical equipment*:

A. Braces.

B. Canes.

C. Crutches.

D. Intermittent positive pressure breathing machine.

E. Hospital beds.

F. Standard *outpatient* oxygen delivery systems.

G. Traction equipment.

H. Standard walkers.

I. Standard wheelchairs.

J. Other items that are determined by *us* to be *medically necessary*.

Covered expenses under this provision also include:

A. The administration, maintenance, and operating costs of the *durable medical equipment*.

B. Replacements, repairs, and adjustments necessary due to wear and tear or because of a significant change in the *covered person's* physical condition.

Exclusions: *Covered expenses* do not include the charges for:

A. Optional attachments and modifications for the comfort or convenience of the *covered person*.

B. Accessories for portability or travel.

C. A second piece of equipment, with or without additional accessories, that is for the same or similar medical purpose as existing equipment.

D. Costs of remodeling the *covered person's* home or car.

E. Replacement of lost or stolen equipment.

Definition:

"*Durable medical equipment*" means items that are:

A. Used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*;

B. Can withstand repeated use;

C. Generally not useful to a person in the absence of *illness* or *injury*.

D. Appropriate for use in the patient's home; and

E. Prescribed by a *doctor*.

EMERGENCY: *Covered expenses* include the charges incurred for *emergency* treatment of an *injury* or *illness,* even if confinement is not required.

FAMILY PLANNING: *Covered expenses* include the charges incurred by a *covered person* for:

A. Sterilization procedures.

B. *Medically necessary* diagnostic and therapeutic *infertility* services, limited to:

1. Laboratory studies;
2. Diagnostic procedures; and
3. Artificial insemination services, limited to a lifetime maximum of 6 cycles per *covered person*.

Definition:

"*Infertility*" means the condition of a presumably healthy individual of child-bearing age who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

GENETIC DISEASE TESTING: *Covered expenses* include the charges incurred by a *covered person* for *genetic disease testing* when:

A. The testing is prescribed following the *covered person's* history, physical examination, and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected;

B. The *covered person* displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and

C. The result of the test will directly impact the *covered person's* treatment.

Definition:

"*Genetic disease testing*" means the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Such purposes include those test meeting criteria for the medically accepted standard of care for the prediction of disease risks, identification of carriers, monitoring, diagnosis, or prognosis, but do not include tests conducted purely for research.

HABILITATIVE SERVICES: *Covered expenses* include the charges incurred for *habilitative services* for a *covered person* with a disabling condition when both of the following conditions are met:

A. The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, or *doctor*.

B. The initial or continued treatment must be proven and not *experimental or investigational treatment*.

We will determine if benefits are available by reviewing both the skilled nature of the *habilitative service* and the need for *doctor*-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered *habilitative services.* A service will not be determined to be skilled simply because there is not an available caregiver.

Limitations: *Covered expenses* are limited to 60 visits per *covered person* per calendar year.

Definition:

"Habilitative services" means *medically necessary* skilled health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.. A *habilitative service* is skilled when all of the following are true:

A. The service is part of a prescribed plan of treatment or maintenance program that is *medically necessary* to maintain a *covered person's* current condition or to prevent or slow further decline.

B. The service is ordered by a *doctor* and provided and administered by a licensed provider.

C. The service 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.

D. The service requires clinical training in order to be delivered safely and effectively.

E. The service is not *custodial care.*

Habilitative services do not include:

A. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

B. *Custodial care,* respite care, day care, therapeutic recreation, vocational training, and residential treatment.

C. A service that does not help the *covered person* to meet functional goals in a treatment plan within a prescribed time frame.

HEARING AIDS AND EXAMS: *Covered persons* include the charges incurred by a *covered person* for:

A. Hearing exams to diagnose an *illness* or *injury*.

B. *Hearing aids* recommended in writing by a *doctor* as required for the correction of a hearing impairment, including related fitting and testing.

C. Repairs and replacement of *hearing aids* once every 3 years.

D. One (1) bone anchored *hearing aid* for a *covered person* who has:

1. Craniofacial anomalies with abnormal or absent ear canals that preclude the use of a wearable *hearing aid*; or

2. Hearing loss of sufficient severity that it would not be adequately remedied by a wearable *hearing aid*.

E. Repair and/or replacement of a bone anchored *hearing aid* only if necessary due to a malfunction.

Definition:

"*Hearing aid*" means a wearable electronic amplifying device designed to bring sound more effectively into the ear. A *hearing aid* consists of a microphone, amplifier, and receiver.

HOME HEALTH CARE: *Covered expenses* include the charges incurred by a *covered person* for the following *home health care* services when provided by a *home health care agency*:

A. The professional services of a registered nurse, licensed practical nurse, or a licensed vocational nurse on an intermittent basis.

B. Physical therapy, speech therapy, and occupational therapy provided by a licensed therapist.

C. Medical and surgical supplies that are customarily provided by the *home health care agency* for its patients.

D. *Prescription drugs* provided and charged for by the *home health care agency*. This does not include specialty drugs.

E. One (1) medical social service consultation per course of treatment.

F. One (1) nutrition consultation by a certified registered dietitian.

G. Home health aide services provided to the *covered person* only when receiving nursing services or therapy.

Limitations: The *covered person* must be homebound for medical reasons, physically not able to obtain necessary medical care on an *outpatient* basis, and under the care of a *doctor*.

Exclusions: *Covered expenses* do not include housekeeping or meal services.

Definitions:

"*Home health care*" means care provided under a *doctor's* orders by a *home health care agency* in the *covered person's* home. The *home health care* must be provided in place of care as an *inpatient* in a *hospital* or *extended care facility*.

"*Home health care agency*" means a licensed *home health care* provider or an approved *hospital* program for *home health care*.

HOSPICE: *Covered expenses* include the charges made by a *hospice* care facility for:

A. Daily room and board and nursing services, not to exceed the *hospice's* most common semi-private room rate.

B. Daily room and board and nursing services in a private room, but only if a private room is *medically necessary* for treatment of the *covered person's* condition.

C. Daily room and board and nursing services while confined in an *intensive care unit*.

D. Bed, board, and nursing services for an observation unit, not to exceed 23 hours per day.

E. Services and supplies, including drugs and medicines, that are routinely provided by the *hospice* to persons for use only while they are *inpatients*.

F. Private duty nursing.

G. Supportive services for the *covered person's* family, including respite care.

H. Bereavement services, limited to a maximum of 5 therapy sessions. Treatment must be completed within 6 months of the *covered person's* death.

Definitions:

"*Hospice*" means an institution that:

A. Provides a hospice care program;

B. Is separated from or operated as a separate unit of a *hospital*, *hospital*-related institution, *home health care agency*, mental health facility, *extended care facility*, or any other licensed health care institution;

C. Provides care for the *terminally ill*; and

D. Is licensed by the state in which it operates.

"*Hospice care program*" means a coordinated, interdisciplinary program prescribed and supervised by a *doctor* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family*.

"*Terminally ill*" means a *doctor* has given a prognosis that a *covered person* has six months or less to live.

HOSPITAL: *Covered expenses* include the charges made by a *hospital* for:

A. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.

B. Daily room and board and nursing services in a private room, but only if a private room is *medically necessary* for treatment of the *covered person's* condition.

C. Daily room and board and nursing services while confined in an *intensive care unit*.

D. Bed, board, and nursing services for an observation unit, not to exceed 23 hours per day.

E. *Inpatient* use of an operating, treatment, or recovery room.

F. *Outpatient* use of an operating, treatment, or recovery room for *surgery*.

G. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients*.

H. Anesthesia and its administration.

MANIPULATIVE TREATMENT: *Covered expenses* include the charges incurred by a *covered person* for *manipulative treatment*.

Limitations: *Covered expenses* for manipulative treatment are limited to 20 visits per *covered person* per calendar year.

Exclusions: *Covered expenses* do not include the charges for reductions of fractures or dislocations.

Definition:

"*Manipulative treatment*" means the therapeutic application of chiropractic and/or osteopathic *manipulative treatment* with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore or improve motion, reduce pain, and improve function in the management of an identified neuormusculoskeletal condition.

MEDICAL FOODS: *Covered expenses* include the charges incurred by a *covered person* for *enteral formulas and special food products* for use at home that are prescribed or ordered by a *doctor* for the treatment of inherited metabolic diseases originating from congenital defects or defects arising shortly after birth. The inherited metabolic diseases must be characterized by deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate, or fat.

Limitations: *Covered expenses* for *special food products* are limited to one 30 day therapeutic supply per *covered person* 4 times a year.

Definition:

"*Enteral formulas and special food products*" means food products that are specially formulated to have less than one gram of protein per serving and are intended to be consumed under the direction of a *doctor* for the dietary treatment of an inherited metabolic disease. *Enteral formulas and special food products* do not include a food that is naturally low in protein.

MENTAL DISORDERS AND SUBSTANCE ABUSE: *Covered expenses* include the charges incurred for treatment of *mental disorders* and *substance abuse* by an appropriately licensed provider or facility for the following levels of care:

A. *Inpatient* treatment.

B. Treatment in a *residential treatment facility.*

C. *Partial hospitalization/day treatment*.

D. *Intensive outpatient treatment*.

E. *Outpatient* treatment.

Covered expenses include the following services when provided by or under the direction of a properly qualified behavioral health provider:

A. Diagnostic evaluations, assessment, and treatment planning.

B. Treatment and/or procedures.

C. Medication management and other associated treatments.

D. Individual, family, and group therapy.

E. Provider-based case management services.

F. Crisis intervention.

Exclusions: *Covered expenses* do not include, and no benefits will be paid for, the charges incurred for:

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

B. Outside of initial assessment,:

   1. For services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be *mental disorders* within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

   2. For services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, and paraphilic disorder.

   3. For all unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

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

D. For tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

E. *Transitional living services*.

Definitions: As used in this provision, the following terms have the meanings indicated:

"Intensive outpatient treatment" means a structured *outpatient* treatment program that provides services for at least 3 hours per day, 2 or more days per week, for treatment of *mental disorders* or *substance abuse.*

"Partial hospitalization/day treatment" means a structured ambulatory program that provides

services for at least 20 hours per week for treatment of *mental disorders* or *substance abuse*.

"Transitional living services" means *mental disorder* services and *substance abuse* services that are provided through facilities, group homes, and supervised apartments that provide up to 24-hour supervision and that are either:

A. Sober living arrangements such as drug-free housing or alcohol/drug halfway houses that are intended to provide stable and safe housing, an alcohol/drug-free environment, and support for recovery; or

B. Supervised living arrangements, which are residences such as facilities, group homes, and supervised apartments that are intended to provide persons with stable and safe housing and the opportunity to learn how to manage their activities of daily living.

Transitional living services include those services that may be used as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the *covered person* with recovery.

NECESSARY MEDICAL SUPPLIES: *Covered expenses* include the charges incurred by a *covered person* for:

A. Oxygen and its administration.

B. Blood, blood plasma, blood derivatives, and their administration and processing.

C. Intravenous injections and solutions.

D. *Necessary medical supplies*, including but not limited to:

   1. Catheter and catheter supplies – Foley catheters, drainage bags, irrigation trays.

   2. Colostomy bags and other ostomy supplies.

   3. Dressing/wound care sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lambs wool pads, sterile solutions, ointments, sterile applicators, and sterile gloves.

   4. Elastic stockings.

   5. Enemas and douches.

   6. Intravenous supplies.

   7. Sheets and bags.

   8. Splints, casts, and slings.

   9. Surgical face masks.

   10. Syringes and needles.

Definition: *"Necessary medical supplies"* means medical supplies that are:

A. Necessary to the care or treatment of an *injury* or *illness;*

B. Not reusable or durable medical equipment*;* and

C. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

OBESITY SURGERY: *Covered expenses* include the charges incurred for gastric restrictive surgical services and related complications for a *covered person* who:

A. Has a body mass index (BMI) of greater than $40kg/m^2$; or

B. Is at least 18 years old and:

   1. Has a BMI greater than $35kg/m^2$ with significant co-morbidities; and

   2. Can provide documented evidence that dietary attempts at weight control are ineffective.

The *covered person* must provide documentation supporting the reasonableness and necessity of gastric restrictive *surgery*, including:

A. Compliant attendance at a medically supervised weight loss program within the last 24 months for at least 3 months with documented failure of weight loss;

B. Significant clinical evidence that weight is affecting the *covered person's* overall health and is a threat to life; and

C. A psychological or psychiatric evaluation resulting in a recommendation for gastric restrictive *surgery*.

Limitations:

A. *Covered expenses* are limited to a lifetime maximum of one *medically necessary* gastric restrictive *surgery* per *covered person*.

B. *Network* benefits for obesity *surgery* services are limited to services received at a *designated facility* for obesity *surgery*. Obesity *surgery* services received from a

facility that is not a *designated facility* will be considered to be non-*network* services.

ORAL SURGICAL SERVICES: *Covered expenses* include the charges incurred by a *covered person* for the following oral *surgery* services:

A. For *covered persons* up to age 19, the *medically necessary* treatment of:

   1. Oral cancer;

   2. Dental fractures; and

   3. Dental biopsies.

B. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

C. Removal of teeth that is necessary in order to perform radiation therapy.

D. Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an *injury*. This does not include injuries caused by chewing. Treatment must begin within 10 days after the *injury* occurs and must be completed within 60 days. Examples of services covered under this paragraph include root canal therapy, post, and build up; temporary crowns and partial bridges; fillings; pulpotomy; extraction of broken teeth; incision and drainage; and tooth stabilization through splinting.

Exclusion: *Covered expenses* do not include the charges for removable dental prosthetics, dentures (partial or complete), or subsequent restoration of teeth, including permanent crowns.

PEDIATRIC DENTAL: *Covered dental expenses* include the charges incurred for *dental services* provided to *covered persons* under the age of 19. A *covered person's* eligibility for benefits under this provision will terminate on the last day of the calendar year the *covered person* reaches the age of 19.

Dental non-network providers may bill *you* for any amount up to the billed charge after *we* have paid benefits due under this *policy*. *Dental network providers* have agreed to discounted pricing for *covered dental expenses* with no additional billing to *you* other than *coinsurance percentage* and *deductible amounts*.

No benefits will be paid for charges *incurred* in excess of *eligible dental expenses*. *Eligible dental expenses* under this provision are subject to the *deductible amount* and *coinsurance percentage* shown in the Data Page.

Dental Benefits: *Covered dental expenses* under this Pediatric Dental benefit provision for *covered persons* are limited to the *dental services* described below and as required by Nevada state law for essential health benefits for pediatric dental.

For all *covered dental expenses* under this Pediatric Dental benefit provision, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; study models/diagnostic casts; acid etch; bonding agents.

PREVENTIVE/DIAGNOSTIC SERVICES:

A. Periodic radiographs (X-rays), according to the current intervals recommended by the American Academy of Pediatric Dentistry..

B. Oral evaluations, limited to 2 per calendar year.

C. Dental prophylaxis (cleanings), limited to 2 per calendar year.

D. Fluoride treatment, limited to 1 time per 6 months.

E. Sealant, limited to once per permanent molar.

F. Space maintainer.

G. Re-cement space maintainer.

BASIC/ADJUNCTIVE SERVICES:

A. Amalgam and resin base composite restorations.

B. Protective restorations (sedative filling).

C. Palliative (emergency) treatment for dental pain, eliminate acute infection, control bleeding, to prevent pulpal death and/or imminent loss of teeth.

ENDODONTICS:

A. Root canal therapy.

B. Pulpal therapy/resorable filling.

PERIODONTICS:

A. Crown lengthening.

B. Gingivectomy/gingivoplasty.

C. Anatomical crown exposure.

D. Gingival flap procedure.

E. Osseous surgery.

F. Pedicle soft tissue graft procedure.

G. Free soft tissue graft procedure.

H. Provisional splinting.

I. Localized delivery of antimicrobial agents.

J. Periodontal maintenance.

K. Full mouth debridement.

L. Scaling and root planing.

M. Bone replacement graft.

N. Guided tissue regeneration.

O. Biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).

P. Subepithelial connective tissue graft procedure.

Q. Distal or proximal wedge procedure (when not performed in connection with surgical procedures in the same anatomical area).

R. Soft tissue allograft.

S. Provisional splinting.

ORAL SURGERY:

A. Extractions, including anesthesia.

PROSTHODONTIC SERVICES:

A. Crowns.

B. Complete dentures, limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.

C. Partial dentures – maxillary or mandibular resin base or cast metal framework with resin denture base, limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.

MEDICALLY NECESSARY ORTHODONTIC SERVICES:

A *covered person* must satisfy a 24-month *waiting period* under this *policy* before *medically necessary* orthodontic services will be eligible as a *covered dental expense*.

Under this Pediatric Dental benefit provision, orthodontic services are services or supplies furnished by a *dentist* in order to diagnose or correct misalignment of the teeth or the bite. Unless otherwise excluded, orthodontic services will be considered *covered dental expenses* only when the service or supply has been prior authorized to be *medically necessary* and the *covered person* has satisfied the 24-month *waiting period*. PRIOR AUTHORIZATION REVIEW FOR *MEDICALLY NECESSARY* ORTHODONTIC SERVICES IS MANDATORY.

It is *your* responsibility to obtain this prior authorization for all orthodontic services prior to treatment. If *you* do not obtain prior authorization, *we* have the right to deny *your* claim for failure to comply with this requirement. Obtaining prior authorization for *medically necessary* orthodontic services does not guarantee payment under this *policy*.

Services or supplies for comprehensive orthodontic treatment will be prior authorized by *us* to be *medically necessary covered dental expenses* only when those services or supplies are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by *our* dental consultants. *Covered dental expenses* will not include, and no benefits are available for, comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, and/or having horizontal/vertical (overjet/overbite) discrepancies.

For comprehensive orthodontic treatment prior authorized by *us* to be *medically necessary covered dental expenses*, benefits will be paid for *covered persons* in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands and appliances are first placed, or on the date a one-step orthodontic procedure is performed.

If a treatment plan is not submitted, *you* will be responsible for payment of any dental treatment not prior authorized by *us* to be *medically necessary*. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be considered *covered dental expenses* and assigned benefits based on the less costly procedure.

Limitations and Exclusions: No benefits will be paid for any services not identified and included as *covered dental expenses* under this Pediatric Dental benefit provision. *You* will be fully responsible for payment for any services which are not *covered dental expenses* or which exceeds the *eligible dental expense* determined for a *covered dental expense*.

Covered dental expenses will not include, and no benefits will be paid under this Pediatric Dental provision for any charges that are *incurred* for:

A. Any expense or service related to that expense that is:

   1. Not identified as a *covered dental expense* in this Pediatric Dental benefit provision, except for essential health benefits for pediatric dental as required by Nevada state law.

   2. In excess of the *reasonable and customary charge* for that expense.

   3. For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license.

   4. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.

   5. For telephone consultations, for failure to keep a scheduled appointment, and sales tax.

   6. For any *dental service* incurred directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.

   7. For or while receiving investigational treatment or for complications therefrom, including expenses that might otherwise be covered if they were not incurred in conjunction with, as a result of, or while receiving investigational treatment.

   8. As a result of *dental service* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.

   9. As a result of:

      a. *Dental service* necessitated due to any act of declared or undeclared war.

      b. The *covered person* taking part in a riot.

      c. The *covered person's* commission of a felony.

B. Any dental service:

   1. Provided without cost to a *covered person* in the absence of insurance covering the charge.

   2. That exceeds the frequency limitations as identified in this rider.

   3. Performed by a *dentist* who is a member of the *covered person's immediate family*.

   4. Provided prior to the *effective date* or after the termination date of this *policy*.

   5. Received outside of the United States, except for a *dental emergency*.

   6. For the following jaw-joint problems: cranionmandibular joint dysfunction, myofunctional therapy, and physical therapy.

   7. Performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance such as bleaching, personalization, and labial veneers).

C. Bacteriological cultures; and adjunctive pre-diagnostic testing.

D. Sealants for teeth other than permanent molars.

E. Cone Beam Imaging and Cone Beam MRI procedures.

F. Biopsies; vestibuloplasty; tooth transplantation services; and appliance removal.

G. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal; and treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

H. Inlays/onlays; retainer – cast metal or porcelain/ceramic for resin bonded fixed prosthesis; implants; pontics; and crowns, except as expressly provided for under this Pediatric Dental benefit provision.

I. Maxillofacial prosthetic and related services.

J. Reconstructive *surgery* regardless of whether or not the *surgery* is incidental to dental disease, *injury* or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

K. Fixed partial dentures (bridges).

L. Partial dentures, except as expressly provided for under this Pediatric Dental benefit provision.

M. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

N. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

O. Gold foil restorations.

P. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

Q. Athletic mouthguards; semi-precision attachments; occlusal guards; duplicate dentures; replacement of lost or stolen appliances; replacement of orthodontic retainers; harmful habit appliances; treatment splints; bruxism appliance; and sleep disorder appliance.

R. Oral hygiene instructions; plaque control; nutritional counseling; tobacco counseling; charges for completing dental claim forms; photographs; any dental supplies, including but not limited to, take-home fluoride; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; and lab procedures.

S. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the dental visit.

T. Replacement within 60 consecutive months of the last placement for complete and partial dentures.

U. Replacement of complete dentures, removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *dentist*. If replacement is due to patient non-compliance, *you* are liable for the cost of the replacement.

V. *Hospital* costs or any additional fees that the *dentist* or *hospital* charges for treatment at the *hospital* (*inpatient* or *outpatient*).

W. Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting.

X. Orthodontia, unless *covered dental expenses* have been prior authorized to be *medically necessary* and the 24-month *waiting period* has been satisfied. Orthodontia coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, repair of damaged orthodontic appliances and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Y. To alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

Z. Removal of sound functional restorations; temporary prosthetics; provisional crown and provisional prosthesis.

AA. Local anesthesia, except as expressly provided for under the Pediatric Dental benefit provision; trigeminal division block anesthesia; regional block anesthesia; desensitizing medicament or resin; deep sedation/general anesthesia; analgesial/anxiolysis/inhalation of nitrous oxide; intravenous sedation; and non-intravenous conscious sedation.

BB. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

CC. Bone grafts, except as expressly provided for under this Pediatric Dental benefit provision.

DD. Any *dental services* for which benefits are payable under the medical benefits of this *policy*.

Alternate Procedures: If two or more services are considered to be acceptable to correct the same dental condition, the amount payable will be based on the *covered dental expenses* for the least expensive service that will produce a professionally satisfactory result as determined by *us* or *our* representatives.

Requests for Predeterminations: If the total cost for a dental treatment plan is expected to be $300 or more, *we* strongly encourage *you* or *your* covered *dependent* or the *dentist* to request a predetermination from *us*. The request must include information about the treatment plan. *We* will tell the *dentist* what benefit amount *we* expect to pay, subject to the Alternate Procedures provision.

Our estimate is valid for 180 days from the date *we* provide it to the *dentist*, as long as your covered *dependent's* insurance is in force when the *dental service* is *incurred*. If *your* covered *dependent* will not receive the *dental services* within the 180 days, *you* or *your* covered *dependent* or the *dentist* must request another predetermination from *us*. *Dental services* must be *incurred* while *your* covered *dependent* is insured under this *policy*.

Definitions: For the purposes of this Pediatric Dental benefit provision, the following terms have the meanings indicated:

"*Covered dental expense*" means a *dental service* that is:

A. *Incurred* while the *covered person* is insured under this *policy*;

B. Prescribed, ordered, recommended, authorized or approved for a *covered person* by a *dentist*;

C. Dentally necessary;

D. Covered by a specific benefit provision specified in this Pediatric Dental benefit provision or as required by Nevada state law for essential health benefits for pediatric dental;

E. Not excluded in this *policy*; and

F. Allowed under all other applicable terms and conditions of the *policy*.

We will not pay benefits for that part of a *covered expense* which:

A. Is subject to a deductible amount or coinsurance percentage;

B. Exceeds any applicable benefit maximum;

C. Is in excess of the *reasonable and customary charge* for that expense;

D. Exceeds the frequency limits described in this Pediatric Dental benefit provision;

E. Is subject to a *waiting period* (this is applicable to *medically necessary* orthodontic services); or

F. Is otherwise subject to an exclusion or limitation under this *policy*.

"*Dental emergency*" means severe pain, swelling or bleeding of the teeth or supporting tissue which occurs as the direct result of unforeseen events or circumstances and, in the judgment of a reasonable person, requires immediate care and treatment which is sought or received within 24 hours of onset.

"*Dental network*" means a group of *dentists* who have contracts that include an agreed upon price for *dental services*.

"*Dental network provider*" means a *dentist* who has agreed with a *dental network* to provide *dental services* at the contracted rate and who is identified in the most current list of *dental network providers* for the *dental network* shown on the front of *your* dental identification card.

"*Dental non-network provider*" means a *dentist* who has not agreed with a *dental network* to provide *dental services* at the contracted rate.

"*Dental service*" means any of the following services or items that are provided for dental care or treatment provided by a *dentist* to the teeth or supporting tissue:

A. Consultation, advice, diagnosis, *surgery*, visit, or referral;

B. Procedure, treatment, or other care;

C. Supply, equipment; or

D. Drug or medicine.

However, if this Pediatric Dental benefit provision describes only certain services or items as *dental services*, then *we* will only pay benefits for those services or items. In addition, *we* will not pay benefits for any *dental service* unless it satisfies the definition of a *covered dental expense*.

"*Dentally necessary*" means necessary from a dental perspective, satisfying all of the following requirements:

A. Does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment to the *covered person*;

B. Is known to be safe, effective and appropriate by most U.S. *dentists* with regard to accepted standards of dental practice at the time when the *dental service* is provided;

C. Cannot be provided primarily for the comfort or convenience of a *covered person* or *dentist*;

D. Cannot be omitted without an adverse effect;

E. Is appropriate for the *covered person's* diagnosis or symptoms; and

F. Is the most cost-effective treatment that is appropriate for the *covered person's*

diagnosis. This means there is no other similar or alternate *dental service* as determined by *us* available at a lower cost.

A final decision to provide *dental services* can only be made by the *covered person* and his/her *dentist*. However, *we* will determine if a *dental service* is *dentally necessary* based on *our* consultation with an appropriate *dentist*/consultant.

To determine what is *dentally necessary*, *we* may require copies of dental records with information to support that treatment, level or frequency of treatment or that the appliance or device is consistent with the dental condition and accepted standards of dental practice.

The fact that any particular *dentist* may, prescribe, order, recommend, or approve a treatment, test, or procedure does not, of itself, make the treatment, test, or procedure, *dentally necessary*. A determination of what is *dentally necessary* does not constitute a dental treatment decision.

"*Dentist*" means a legally licensed *dentist* practicing within the scope of the license and currently licensed by the state in which the services are provided. *Dentist* also includes:

A. A legally licensed oral surgeon, endodontist, orthodontist, periodontist, prosthodontist and pedodontist, practicing within the scope of his or her license; and

B. A legally licensed dental hygienist practicing within the scope of the license while under the supervision of a *dentist*.

A *dentist* cannot be an *immediate family* member of a *covered person*.

"*Eligible dental expense*" means a *covered dental expense* as determined below:

A. For dental network providers: When a covered dental expense is received from a dental network provider, the eligible dental expense is the contracted fee with that provider.

B. For dental non-network providers: When a covered dental expense is received from a dental non-network provider, the eligible dental expense is the reasonable and customary charge.

"*Incurred*" means that a *dental service* has been provided to a *covered person* and a fee or charge is owed to the *dentist* for the service. *Covered dental expenses* for *dental services* will be considered to be incurred for:

A. Appliances or a modification of appliances on the date the master impression is made;

B. A crown, a bridge, a veneer or inlay or onlay restoration on the date the tooth or teeth are prepared;

C. Root canal therapy on the date the pulp chamber is opened; and

D. All other charges on the date the *dental service* is rendered or a supply furnished.

"*Reasonable and customary charge*" means, with respect to fees charged, a fee calculated by *us* based on available date resources (Ingenix Survey of Dental Charges) of competitive fees in that geographic area. A fee will not be a *reasonable and customary charge* if it exceeds what the provider would charge any similarly situated payor for the same services. If a provider routinely waives coinsurance and/or the annual deductible for benefits, the fee for the *dental services* for which the coinsurance and/or the annual deductible are waived will not be a *reasonable and customary charge*.

Reasonable and customary charges are determined solely in accordance with *our* reimbursement policy guidelines. The reimbursement policy guidelines are developed by *us*, at *our* discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

A. As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).

B. As reported by generally recognized professionals or publications.

C. As utilized for Medicare.

D. As determined by medical or dental staff and outside medical or dental consultants.

E. Pursuant to any other appropriate source or determination accepted by *us*.

"*Waiting period*" means a period of time for which a *covered person* must wait, after the *effective date* of coverage, before *medically necessary* orthodontic services listed in this Pediatric Dental benefit provision will be covered.

PEDIATRIC VISION: *Covered expenses* include vision services provided to *covered persons* under the age of 19 years. A *covered person's* eligibility for benefits under this provision will terminate on the last day of the calendar year the *covered person* reaches the age of 19.

How the Vision Benefit Program Works: When obtaining services from a *vision network provider*, *you* will be required to pay the *vision network provider* any *deductible amount* and *coinsurance percentage*, as shown in the Data page.

To locate a *vision network provider*, *you* can contact the provider locator service at (800) 638-3120. *You* can also access a listing of *vision network providers*, as well as other important information regarding *your* vision coverage, by visiting *our* vision website at [www.myuhcvision.com]. Identify yourself as having UnitedHealthcare Vision coverage and provide *your* identification number when scheduling an appointment with a *vision network provider*.

When obtaining services from a *vison non-network provider*, a reduction in benefits may apply, as shown in the Data Page. *You* will be required to pay all billed charges directly to the *vision non-network provider* at the time of service. *You* may then seek reimbursement from *us* by providing: (1) *your* name and identification number; (2) itemized paid receipts; (3) patient's name and date of birth. Submit this information to *us* by facsimile (fax) at [248-733-6060] or by mail to:

[UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130]

Covered Expenses: Benefits are limited to charges *incurred* for the vision services described below, per *covered person*, but only when each service is a *covered expense*:

A. *Routine vision examinations*. Benefits are limited to 1 exam every calendar year.

B. Prescription eyewear. Benefits are limited to 1 pair of prescription *eyeglass lenses* every calendar year and 1 *eyeglass frame* every calendar year, or a 12-month supply of *contact lenses* from the *covered contact lens selection* or *necessary contact lenses*:

   1. *Eyeglass lenses*, including single vision, bifocal, trifocal, lenticular lenses and *optional lens extras*, as prescribed by an ophthalmologist or optometrist; *eyeglass frame* and their fitting and subsequent adjustments to maintain comfort and efficiency; or

   2. Contact lenses that are in lieu of eyeglass lenses and eyeglass frame; or

   3. *Necessary contact lenses*: This benefit is available when a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by *us*. *Contact lenses* are necessary if the *covered person* has:

      a. Keratoconus;

      b. Pathological myopia;

      c. Aniseikonia;

      d. Aniridia;

      e. Anisometropia;

      f. Irregular astigmatism;

      g. Aphakia;

      h. Post traumatic disorder; or

      i. Corneal disorders.

C. Low Vision Benefit. The low vision benefit is available to a *covered person* who has severe visual problems that cannot be corrected with regular lenses. This benefit is available where a vision provider has determined a need for and has prescribed the service. Such determination will be made by the vision provider and not by *us*. Benefits are limited to once every 24 months. This benefit includes:

   1. Low vision testing: Complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. *You* will be reimbursed 100% of billed charges for *covered expenses* after the *deductible amount*, as shown in the Data Page, has been met.

   2. Low vision therapy: Subsequent low vision therapy if prescribed. *You* will be reimbursed 75% of billed charges for *covered expenses* after the *deductible amount*, as shown in the Data Page, has been met.

   3. Low vision aids, if prescribed, such as spectacles, magnifiers, and telescopes. *You* will be reimbursed 75% of billed charges for *covered expenses* after the *deductible amount*, as shown in the Data Page, has been met.

You will be required to pay all billed charges for low vision services at the time of service. *You* may then seek reimbursement from *us* by providing: (1) *your*

name and identification number; (2) itemized paid receipts; and (3) patient's name and date of birth. Submit this information to *us* by mail to:

[UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130-0549]

Exclusions and Limitations: No benefits will be paid for any service not identified and included as a *covered expense* under this Pediatric Vision benefit provision. *You* will be fully responsible for payment for any service which is not a *covered expense* or which exceeds the *eligible expense* determined for a *covered expense*. *Covered expenses* will not include, and no benefits are payable under this Pediatric Vision benefit provision for any charges *incurred* for the following:

A. Orthoptics or vision therapy training and any associated supplemental testing.
B. Non-prescription items (e.g. plan lenses).
C. Replacement of *eyeglass lenses* and *eyeglass frame* furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
D. Medical or surgical treatment of the eyes.
E. Missed appointment charges.
F. Applicable sales tax charge on vision care services.
G. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
H. *Contact lenses* if *eyeglass lenses* and an *eyeglass frame* are received in the same calendar year.
I. *Eyeglass frame* and *eyeglass lenses* if *contact lenses* are received in the same calendar year.
J. Services or treatments that are already excluded in the General Exclusions and Limitations section of this *policy*.

Health Insurance for Vision Services: If any *covered expenses* under this benefit provision are also payable under health insurance or other health coverage, *we* will not make payment under this vision benefit provision until after *we* determine what benefits are paid or payable by the health insurance or other health coverage plan.

Our payment under this vision benefit provision will be reduced by the amount of any benefits that are payable for a *covered person* by any other vision or health plan.

Coverage Under Other *Policy* Provisions: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy*.

Definitions: As used in this Pediatric Vision benefit provision, the following terms have the meanings indicated:

"*Contact lenses*" are lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

"*Covered contact lens selection*" means a selection of available contact lenses that may be obtained from a *vison network provider*, subject to the payment of any applicable *deductible amount* and *coinsurance percentage*.

"*Eyeglass frame*" means a structure that contains *eyeglass lenses*, holding the lenses in front of the eyes and are supported by the bridge of the nose.

"*Eyeglass lenses*" are lenses that are mounted in an *eyeglass frame* and worn on the face to correct visual acuity limitations.

"*Vision network provider*" means any optometrist, ophthalmologist, or other person may lawfully provide services who has agreed with a *network* to provide vision services covered by this plan at a contracted rate.

"*Vision non-network provider*" means any optometrist, ophthalmologist, or other person who may lawfully provide services who has not agreed with a *network* to provide vision services covered by this plan at a contracted rate.

"*Optional lens extras*" are special lens stock or modifications to lenses that do not correct visual acuity problems. Optional lens extras include: ultraviolet protective coating, polycarbonate lenses, scratch resistant-coating, fashion and gradient tinting, oversized, glass-grey #3 prescription sunglass lenses, blended segment lenses, intermediate vision lenses, standard progressive lenses, premium progressives, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard anti-reflective coating, premium anti-reflective coating, ultra anti-reflective coating and hi-index lenses.

"*Routine vision examination*" is an examination of the eyes and principal vision functions according to

the standards of care in the jurisdiction in which the *covered person* resides, to include:

A. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.

B. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.).

C. Cover test at 20 feet and 16 inches (checks eye alignment).

D. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.

E. Pupil responses (neurological integrity).

F. External exam.

G. Pupil dilation, when professionally indicated.

H. Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses, subjective refraction – to determine lens power of corrective lenses.

I. Phorometry/Binocular testing – far and near (how will eyes work as a team).

J. Tests of accommodation and/or near point refraction (how well a *covered person* sees at near point (ie: reading, etc.)).

K. Tonometry, when indicated (tests pressure in eye – glaucoma check).

L. Ophthalmoscopic examination of the internal eye.

M. Confrontation visual fields.

N. Biomicroscopy.

O. Color vision testing.

P. Diagnosis/prognosis.

Q. Specific recommendations.

Post examination procedures will be performed only when materials are needed.

PHYSICIAN SERVICES: *Covered expenses* include the charges:

A. Made by a *doctor* for professional services for non-surgical procedures to diagnose or treat an *illness* or *injury*, performed in the *doctor's* office, the *covered person's* home, or a licensed healthcare facility.

B. Made by a *doctor* for professional services for *surgery*.

C. For an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure*.

D. For a *doctor*, who is acting as a surgical assistant, limited to 14 percent of the *eligible expense* for the *surgical procedure*.

E. For anesthesia services.

PREGNANCY: *Covered expenses* include the charges incurred for normal pregnancy, childbirth, and any *complications of pregnancy*.

Newborns' and Mothers' Health Protection Act Statement of Rights: Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by caesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Definitions:

"Complications of pregnancy" means:

A. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *doctor* prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.

B. An *emergency* caesarean section or a *non-elective caesarean section*.

"Non-elective caesarean section" means:

A. A caesarean section where vaginal delivery is not a medically viable option; or

B. A repeat caesarean section.

PRESCRIPTION DRUGS - OUTPATIENT: *Covered expenses* for *outpatient prescription drugs* are limited to charges from a licensed pharmacy for drugs which, under applicable state law, may be dispensed only upon the written prescription of a *doctor*.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *doctor*.

Notice and Proof of Loss: In order to obtain payment for *covered expenses* incurred at a pharmacy for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us*.

Prior Authorization Requirements: Before certain *prescription drugs* are dispensed to *you*, either *your medical practitioner, your* pharmacist, or *you* are required to obtain prior authorization from *us* or *our* designee. The reason for obtaining prior authorization is to determine whether the *prescription drug,* in accordance with *our* approval guidelines, meets the definition of a *covered expense* and is not *experimental or investigational treatment* or an *unproven service*.

Prior authorization may also be required:

A. To determine if the *prescription drug* was prescribed by a *specialist physician*.

B. For certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits.

The *prescription drugs* requiring the prior authorization are subject to periodic review and modification. *You* may access information on available programs and any applicable prior authorization, participation, or activation requirements through the Internet at [website address] or by calling the telephone number on *your* identification card.

If prior authorization is not obtained from *us* or *our* designee before the *prescription drug* is dispensed, *you* may pay more for that *prescription order* or refill. *You* will be required to pay for the *prescription drug* at the pharmacy. *You* can submit a claim to ask *us* to consider reimbursement after *you* receive the *prescription drug*.

Prescription Drug List: *Covered expenses* for *prescription drugs* are limited to those included in the Prescription Drug List (*"PDL"*) provided by *our* pharmacy benefits manager, OptumRx, at the time *your prescription order* is filled (formulary drugs). The *PDL* is determined by the UnitedHealthcare Prescription Drug List Management Committee comprised of senior level UnitedHealth Group physicians and business leaders. Their goal is to help ensure access to a wide range of medications while helping to control health care costs. As affiliates of UnitedHealthcare, both *we* and OptumRx use this *PDL* to administer *prescription drug* benefits.

You may be entitled to benefits for a *prescription drug* not included in the *PDL* (non-formulary drugs) without any additional cost sharing beyond that required of formulary drugs if:

A. After consultation with *your doctor, we* determine that the formulary drugs are inappropriate therapy for *your* condition; or

B. *You* have been using the non-formulary drug for 6 months prior to its exclusion from the *PDL*, and *your doctor* determines that either the formulary drug is inappropriate therapy for *your* condition or that changing the drug therapy presents a significant health risk.

You must use the prior authorization process described in this Prescription Drugs benefit provision to request a non-formulary drug that is not included in the *PDL*.

Your Right to Request an Exclusion Exception: When a *prescription drug* is excluded from coverage, *you* or *your* representative may request an exception to gain access to the excluded *prescription drug.* To make a request, contact *us* in writing or call the telephone number on *your* identification card. *We* will notify *you* of *our* determination within 72 hours of *our* receipt of the request.

Urgent Requests: If *your* request requires immediate action and a delay could significantly increase the risk to the *covered person's* health or the ability to regain maximum function, call *us* as soon as possible. *We* will provide a written or electronic determination within 24 hours of *our* receipt of the request.

External Review: If *you* are not satisfied with *our* determination, *you* may be entitled to request an

external review. *You* or *your* representative may request an external review by sending a written request to *us* at the address provided in the determination letter or by calling the telephone number on *your* identification card. The Independent Review Organization (IRO) will notify *you* of its determination within 72 hours of receipt of the request.

Expedited External Review: If *you* are not satisfied with *our* determination and it involves an urgent situation, *you* or *your* representative may request an expedited external review by calling the telephone number on *your* identification card or by sending a written request to the address provided in the determination letter. The IRO will notify *you* of its determination within 24 hours of receipt of the request.

SUPPLY LIMITS: An otherwise covered *prescription drug* which is dispensed by a pharmacy for a less than 30-day supply will be a *covered expense* if the *prescription drug* is being dispensed for the purpose of synchronizing the *covered person's* medical condition if:

A. The prescriber or pharmacist determines that filling or refilling the *prescription drug* in that manner is in the best interest of the *covered person*; and

B. The *covered person* request less than a 30-day supply.

Early refills for a covered *topical ophthalmic product* will be a *covered expense* when the *covered person* receives a refill of the *topical ophthalmic product* from a pharmacist:

A. After 21 days or more but before 30 days after receiving a 30-day supply;

B. After 42 days or more but before 60 days after receiving a 60-day supply; or

C. After 63 days or more but before 90 days after receiving any 90-day supply.

Coupons: *We* may not permit certain coupons or offers from pharmaceutical manufacturers to apply to the *deductible amount, copayment amount* (if any), coinsurance, and/or *network* out-of-pocket maximum. *You* may access information on which coupons or offers are not permitted through the Internet at [website address] or by calling the telephone number on *your* identification card.

Exclusions and Limitations: No benefits will be paid under this benefit subsection for expenses incurred:

A. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.

B. For immunization agents (except as covered under the Preventive Care benefit provision in this *policy*), blood, or blood plasma.

C. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed.

D. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

E. For a refill dispensed more than 12 months from the date of a *doctor's* order.

F. Due to a *covered person's* addiction to, or dependency on, foods.

G. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

H. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is *therapeutically equivalent,* except as covered under the Preventive Care benefit provision in this *policy*.

I. For a *prescription drug* that contains (an) active ingredient(s) that is/are:

   1. Available in and *therapeutically equivalent* to another covered *prescription drug*; or

   2. A modified version of and *therapeutically equivalent* to another covered *prescription 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* that was previously excluded under this paragraph.

J. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.

K. In excess of the maximum allowable charge paid for a *therapeutic class* of/*therapeutically equivalent prescription drugs*.

L. For more than a 34-day supply when dispensed in any one prescription or refill.

M. In excess of the cost of the generic equivalent, if any, regardless of whether the

doctor specifies name brand on the written prescription.

N. For compounded drugs that:

   1. Do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and require a *prescription order* or refill.

   2. Contain a non-FDA approved bulk chemical.

   3. Are available as a similar commercially available *prescription drug*.

O. For a *prescription drug* with an approved *biosimilar* or a *biosimilar* and *therapeutically equivalent* to another covered *prescription drug*. Such determinations may be made up to six times during a calendar year.

P. For certain *prescription drugs* for which there are *therapeutically equivalent* alternatives available, unless otherwise required by law or approved by *us*. Such determinations may be made up to six times during a calendar year.

Q. For diagnostic kits and products.

R. For publicly available software applications and/or monitors that may be available with or without a *prescription order* or refill.

S. For a *prescription drug* received from a non-*member pharmacy*, or from a *member pharmacy* when a *prescription drug card* is not used, unless as a result of an *emergency*.

Covered expenses for the treatment of tobacco cessation include the charges for one *prescription drug* in each drug classification. No benefits will be paid for other expenses incurred due to addiction to, or dependency on, tobacco, except as required for *covered expenses* under the Preventive Care benefit provision in this *policy*.

Definitions: As used in this benefit subsection, the following terms have the meanings indicated:

"Biosimilar" means a biological *prescription drug* approved by the U.S. Food and Drug Administration (FDA) based on showing that it is highly similar to a reference product (a biological *prescription drug)* and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

"Managed drug limitations" means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

"Prescription drug" means any medicinal substance whose label is required to bear the legend "RX only."

"Prescription order" means the request for each separate drug or medication by a *doctor* or each authorized refill of such requests.

"Therapeutic class" means a group or category of *prescription drugs* with similar uses and/or actions.

"Therapeutically equivalent" means that two or more *prescription drugs* can be expected to produce essentially the same therapeutic outcome and toxicity.

"*Topical ophthalmic product*" means a liquid *prescription drug* which is applied directly to the eye from a bottle or by means of a dropper.

PREVENTIVE CARE: *Covered expenses* include the charges incurred by a *covered person* for the following preventive health services, if appropriate for the *covered person* and in accordance with the following recommendations and guidelines as required under applicable law:

A. Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. *You* can access a list of the current A & B preventive care recommendations at www.HealthCare.gov or www.uspreventiveservicestaskforce.org.

B. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

C. Evidence-informed preventive care and screenings for infants, children and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.

D. Additional preventive care and screenings not described in A above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

With the exception of the application of reasonable medical management techniques as detailed in the

following paragraph, the listed preventive care services are exempt from *deductible amounts,* coinsurance and *copayment amounts* when services are provided by a *network provider*.

Benefits for preventive care expenses may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. When a *covered person* chooses not to use a high value preventive service (as identified on [website address]), *deductible amounts,* coinsurance, and/or *copayment amounts* may be applied.

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services.

Services of Non-Network Providers: *Covered expenses* incurred at a non-*network provider* will be reduced by 25%, then subject to the applicable *deductible amount* and *coinsurance percentage*.

PROSTHETIC AND ORTHOTIC DEVICES: *Covered expenses* include the charges incurred by a *covered person* for the following *prosthetic devices* and *orthotic devices* when received in connection with a covered *illness* or *injury*:

A. Cardiac pacemakers.

B. Breast prostheses for post-mastectomy patients. (Also see the Reconstructive Surgery benefit provision.)

C. Terminal devices (examples are hand or hook) and artificial eyes.

D. Braces, which include only rigid and semi-rigid devices used for supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured body part.

Covered expenses also include adjustment of an initial *prosthetic device* or *orthotic device* when ordered by a *doctor* and required by wear or by a change in the *covered person's* condition.

Definitions:

"*Orthotic device*" means a device used to support, align, prevent, or correct a deformity or to improve the function of a movable part of the body.

"*Prosthetic device*" means a non-experimental device that replaces all or part of a body part of organ or replaces all or part of the function of a permanently inoperative malfunctioning body part or organ.

RECONSTRUCTIVE SURGERY: *Covered expenses* include the charges incurred by a *covered person* for:

A. *Reconstructive surgery*.

B. The following, when provided to a *covered person* who is receiving benefits for *covered expenses* in connection with a mastectomy and who elects breast reconstruction:

   1. All stages of reconstruction of the breast on which the mastectomy has been performed.

   2. *Surgery* and reconstruction of the other breast to produce a symmetrical appearance.

   3. Prostheses and treatment for physical complications of mastectomy, including lymphedemas.

   4. If breast reconstruction is begun within 3 years after a mastectomy, and if this *policy* was in effect at the time of the mastectomy, benefits will be provided subject to the terms, conditions, limitations, and exclusions of this *policy* at the time of the mastectomy. If this *policy* was not in effect at the time of the mastectomy, or if breast reconstruction is begun more than 3 years after the mastectomy, benefits will be provided subject to the terms, conditions, limitations, and exclusions of this *policy* at the time of the breast reconstruction.

Exclusion: *Cosmetic treatment* is not covered.

Definition:

"Reconstructive surgery" means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function, to the extent possible.

REHABILITATION AND EXTENDED CARE FACILITY SERVICES: *Covered expenses* include the charges incurred by a *covered person* for *rehabilitation therapy* services received on an *inpatient* or *outpatient* basis.

Covered expenses include the charges made by an *extended care facility* for:

A. Daily room and board and nursing services not to exceed the *extended care facility's* most common semi-private room rate.

B. Daily room and board and nursing services in a private room, but only if a private room is *medically necessary* for treatment of the *covered person's* condition.

C. Daily room and board and nursing services while confined in an *intensive care unit*.

D. Bed, board, and nursing services for an observation unit, not to exceed 23 hours per day.

E. Services and supplies, including drugs and medicines, that are routinely provided by the *extended care facility* to persons for use only while they are *inpatients*.

F. Private duty nursing.

Limitations:

A. *Covered expenses* for *extended care facility* services are limited to a maximum of 100 days per *covered person* per calendar year.

B. *Covered expenses* for *inpatient* and *outpatient rehabilitation therapy* services are limited to a combined maximum of 60 days and/or visits per *covered person* per calendar year.

Exclusions: *Covered expenses* do not include the charges incurred for cardiac rehabilitation services provided on a non-monitored basis.

Definitions:

"Acute rehabilitation" means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital, rehabilitation facility,* or *extended care facility*.

"Intensive day rehabilitation" means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

"Maximum therapeutic benefit" means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

"Medically stabilized" means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

"Pain management program" means a program using interdisciplinary teams providing coordinated, goal oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning. The purpose of a *pain management program* is to reduce pain, improve function, and decrease dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

"Provider facility" means a *hospital, rehabilitation facility*, or *extended care facility*.

"Rehabilitation" means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation, subacute rehabilitation,* or *intensive day rehabilitation,* and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

"Rehabilitation facility" means an institution or a separate identifiable *hospital* unit, section, or ward that:

A. Is licensed by the state as a *rehabilitation facility;* and

B. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care or for care of the mentally incompetent.

"Rehabilitation medical practitioner" means a *doctor*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical 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.

"Rehabilitation therapy" means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

"Subacute rehabilitation" means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital, rehabilitation facility,* or *extended care facility*.

SUBSTANCE ABUSE TREATMENT: Please see the Mental Disorders and Substance Abuse benefit provision.

SURGERY – OUTPATIENT: *Covered expenses* include the charges incurred by a *covered person* for *surgery* in a *doctor's* office or at an *outpatient surgical facility*, including services and supplies.

TELEHEALTH: *Covered expenses* include the charges incurred by a *covered person* for services or treatments of a *medical practitioner* through *telehealth* if those services or treatments would otherwise be *covered expenses* under the *policy*.

Prior authorization will only be required for services/treatments received through *telehealth* if prior authorization is required for those services or treatments when not received through *telehealth*.

Nothing in this provision requires that:

A. *Telehealth* services be made available to a *covered person* at a particular originating site;

B. *Covered expenses* include charges incurred by a *covered person* for *telehealth* services/treatments which would not be considered *covered expenses* when not received through *telehealth*; or

C. *We* enter into any contract or agreement with a *medical practitioner* to treat charges incurred by a *covered person* for services or treatments through *telehealth* as *covered expenses* if those services/treatments would not otherwise be *covered expenses* under the *policy*.

Definition:

"*Telehealth*" means the delivery of services from a *medical practitioner* to a *covered person* at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile, or electronic mail.

TEMPOROMANDIBULAR JOINT: *Covered expenses* include the charges incurred by a *covered person* for surgical and non-surgical treatment of the temporomandibular joint, including *medically necessary* dental procedures, such as dental splints.

THERAPEUTIC TREATMENTS: *Covered expenses* include the charges incurred by a *covered person* for:

A. Chemotherapy.

B. Radiation therapy.

C. Hemodialysis and peritoneal renal dialysis.

D. Intravenous therapeutic services, including, but not limited to, non-cancer related intravenous injection therapy.

TRANSPLANTS: *Covered expenses* include the charges incurred by a *covered person* for *medically necessary* solid organ transplants and non-solid organ transplants that are not *experimental or investigational treatment*.

If *we* determine that a *covered person* is an appropriate candidate for a transplant, *covered expenses* will include charges incurred for:

A. Pre-transplant evaluation.

B. Pre-transplant harvesting.

C. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs.

D. Organ and tissue retrieval, which includes removing and preserving the donated part.

E. High dose chemotherapy.

F. Peripheral stem cell collection.

G. The transplant itself, not including the acquisition cost for the organ or bone marrow.

H. Post transplant follow-up.

I. Private nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).

Travel and Lodging: *Covered expenses* include travel and lodging for the *covered person*, any live donor, and the *immediate family* to accompany the *covered person* to and from the transplant facility. *Covered expenses* under this paragraph are limited to $5,000.

Limitation:

A. Benefits for services to retransplant a previously transplanted organ or tissue are limited to 50% of *eligible expenses*.

B. Benefits for procurement procedures and/or services are limited to those deemed by *us* to be *medically necessary* and appropriate for an approved organ transplant.

C. *Network* benefits for transplant services are limited to services received at a *designated facility* for transplants. Transplant services received from a facility that is not a *designated facility* will be considered to be non-*network* services.

Exclusions: No benefits will be paid for charges:

A. All services or supplies, treatments, laboratory tests, or x-rays received by the donor in connection with the transplant.

B. For search and testing in order to locate a suitable donor.

C. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.

D. For animal to human transplants.

E. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.

F. To keep a donor alive for the transplant operation.

G. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.

H. For a transplant under study in an ongoing phase I or II *clinical trial* as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

URGENT CARE SERVICES: *Covered expenses* include the charges incurred for services, including professional services, received at an *urgent care center.*

Section 8
PRIOR AUTHORIZATION

PRIOR AUTHORIZATION REQUIRED: Some *covered expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *eligible expenses* for which *you* must obtain the prior authorization even when provided by a *network provider*.

In general, for services or supplies that require prior authorization, as shown in the Data Page, *you* must obtain authorization from *us* before the *covered person:*

A. Receives a service or supply from a non-*network provider;*

B. Is admitted into a *network* facility by a non-*network provider*; or

C. Receives a service or supply from a *network provider* to which the *covered person* was referred by a non-*network provider*.

HOW TO OBTAIN PRIOR AUTHORIZATION: To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person*.

FAILURE TO OBTAIN PRIOR AUTHORIZATION: Failure to comply with the prior authorization requirements will result in benefits being reduced or denied. Please see the Data Page for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced or denied for failure to comply with prior authorization requirements prior to an *emergency*. However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFITS: *Our* authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of this *policy*.

Section 9
GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be paid for:

A. Any service or supply that would be provided without cost to *you* or *your*

covered *dependent* in the absence of insurance covering the charge.

B. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.

C. Any services performed by a member of a *covered person's immediate family*.

D. Any services not identified and included as *covered expenses* under this *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses*.

E. Charges incurred that are in excess of *eligible expenses*.

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

A. Administered or ordered by a *doctor;* and

B. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care benefit provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.

B. For weight modification, or for surgical treatment of obesity, including wiring of the teeth, except as expressly provided for in the Medical Benefits section.

C. For breast reduction or augmentation.

D. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person*.

E. For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to artificial insemination or treatment for infertility or impotency, except as expressly provided for in the Medical Benefits section.

F. For reversal of sterilization.

G. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).

H. For expenses for television, telephone, or expenses for other persons.

I. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

J. For telephone consultations or for failure to keep a scheduled appointment.

K. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency,* or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.

L. For stand-by availability of a *doctor* when no treatment is rendered.

M. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery,* except as expressly provided for under this *policy*.

N. For *cosmetic treatment*.

O. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems; occupational, religious, or other social maladjustments; chronic behavior disorders; and codependency.

P. For diagnosis or treatment of nicotine addiction, except as otherwise covered under this *policy*.

Q. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant benefit provision.

R. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

S. While confined primarily to receive *custodial care,* educational care, or nursing services (unless expressly provided for by this *policy*).

T. For vocational or recreational therapy, vocational *rehabilitation, outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *policy*.

U. Except as specifically identified as a *covered expense* under this *policy,* for expenses for alternative treatments or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms

of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health; and wilderness therapy, outdoor therapy, boot camp, equine therapy, art therapy, music therapy, dance therapy,and similar programs.

V. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under this *policy* or in a rider attached to this *policy*.

W. For premarital examinations, and educational programs, except as expressly provided for in this *policy*.

X. For *experimental or investigational treatment(s)* or *unproven services*. The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.

Y. For expenses incurred outside of the United States, except for expenses incurred for *emergency* treatment of a *covered person*.

Z. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.

AA. As a result of:

1. An *injury* or *illness* caused by any act of declared or undeclared war.

2. The *covered person* taking part in a riot.

3. The *covered person's* commission of a felony.

BB. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications therefrom, except as expressly provided for under the Medical Benefits.

CC. For or related to surrogate parenting.

DD. For or related to treatment of hyperhidrosis (excessive sweating).

EE. For fetal reduction *surgery*.

FF. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; or rodeo sports.

GG. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the *covered person* is paid to participate or instruct: operating or riding on a motorcycle; racing or speed testing any non-motorized vehicle or conveyance; horseback riding; rock or mountain climbing; or skiing.

HH. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

II. For routine foot care; nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet; treatment of subluxation of the foot; and shoes, shoe orthotics, shoe inserts, and arch supports.

JJ. For modifications to a *covered person's residence*, including equipment to accommodate physical handicap or disability.

KK. For third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes; exams or treatment ordered by a court or in connection with legal proceedings; and immunizations related to foreign travel.

LL. . For a service for which a non-*network provider* waives, does not pursue, or fails to collect any applicable *copayment amount*,

deductible amount, and/or coinsurance amount owed.

MM. For devices used specifically as safety items or to affect performance in sports-related activities.

NN. For the following items, even if prescribed by a *doctor:*

1. Blood pressure cuff/monitor.
2. Enuresis alarm.
3. Non-wearable external defibrillator.
4. Trusses.
5. Ultrasonic nebulizers.

OO. For oral appliances for snoring.

PP. For medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

QQ. For physical, psychiatric or psychological exams, testing, all forms of vaccinations, and immunizations or treatments that are otherwise covered under this *policy* when:

1. Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
2. Related to judicial or administrative proceedings or orders.
3. Conducted for purposes of medical research, except as provided under the Clinical Trials benefit.
4. Required to obtain or maintain a license of any type.

RR. For individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control, or dietary preferences. This exclusion does not apply to:

1. *Covered expenses* for preventive care as described in the Preventive Care benefit provision.
2. Medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   a. Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   b. There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

SS. For infant formula and donor breast milk.

TT. For 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).

UU. For services:

1. Provided at a *freestanding facility* or diagnostic *hospital*-based facility without an order written by a *doctor* or other provider;
2. That are self-directed to a *freestanding facility* or diagnostic *hospital*-based facility; or
3. Ordered by a *doctor* or other provider who is an employee or representative of a *freestanding facility* or diagnostic *hospital*-based facility, when the *doctor* or provider:
   a. Has not been actively involved in the *covered person's* medical care prior to ordering the service; or
   b. Is not actively involved in the *covered person's* medical care after the service is received.

This exclusion does not apply to mammography.

VV. For services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

LIMITATION ON BENEFITS FOR SERVICES PROVIDED BY MEDICARE OPT-OUT PRACTITIONERS: Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare-participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare-participating practitioner.*)

"Medicare opt-out practitioner" means a *medical practitioner* who:

A. Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and

B. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

"Medicare-participating practitioner" means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Section 10
CONTINUING ELIGIBILITY

FOR ALL COVERED PERSONS: A *covered person's* eligibility for insurance under this *policy* will cease:

A. When a *covered person* is no longer a United States citizen or lawfully present in the United States.

B. On the date a *covered person* no longer resides in the *network service area*.

C. On the date that a *covered person* accepts any direct or indirect contribution or reimbursement by or on behalf of any health care provider or any health care provider sponsored organization for any portion of the premium for coverage under this *policy*.

Residency Requirements: *You* must reside in the *network service area* where this *policy* was issued in order for coverage to remain in force. If *you* move outside of the *network service area*, *you* may designate another *covered person* under this *policy* who is remaining a resident of the *network service area* as the new primary insured. *Covered persons* who meet the definition of *dependent* for the new primary insured may remain covered under this *policy*.

FOR DEPENDENTS: A covered *spouse* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce. A covered child will cease to be a *covered person* at the end of the calendar year in which he or she ceases to be an *eligible child*.

We must receive notification within 90 days of the date a covered *spouse* ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month following the date *we* receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

A. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and

B. Mainly dependent on *you* for support.

Section 11
TERMINATION

TERMINATION OF POLICY: All insurance will cease on termination of this *policy*. This *policy* will terminate:

A. If premiums are not received by *us* when due, subject to the Grace Period provision in this *policy*.

B. If *we* decline to renew this *policy,* as stated in the Guaranteed Renewable provision or as explained in the Discontinuance provision.

C. On the date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request.

D. On the date of *your* death, if this *policy* covers only *you*.

E. On the date all *covered persons'* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the For All Covered Persons provision in the Continuing Eligibility section in this *policy*.

We will refund any premium paid and not earned due to *policy* termination.

This *policy* may also terminate due to changes in the actuarial value requirements under state or federal law. If this *policy* terminates for this reason, a new policy will be issued to *you*.

If this *policy* covers *you* and *your spouse* and/or child(ren), it may be continued after *your* death by *your spouse*, if a *covered person;* otherwise, by the youngest child who is a *covered person*. *Your spouse* or youngest child will replace *you* as the

insured. *We* will refund any premium paid and not earned due to *your* death.

DISCONTINUANCE:

If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 180 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual policies/certificates in the individual market in the state where *you* reside.

Section 12
CLAIMS

CLAIM FORMS: *We* will furnish claim forms after *we* receive notice of a claim. If *our* usual claim forms are not furnished within 15 days, *you* or *your* covered *dependent* may file a claim without them. The claim must contain written *proof of loss*.

NOTICE OF CLAIM: *We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

PROOF OF LOSS: *You* or *your* covered *dependent* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or your covered *dependent* had no legal capacity in that year.

COOPERATION PROVISION: Each *covered person,* or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under this *policy* and, as often as may be reasonably necessary:

A. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.

B. Obtain and furnish to *us,* or *our* representatives, any medical or other information, records or documents *we* deem relevant.

C. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.

D. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us,* or *our* representative, any information, records or documents requested by *us*).

If any *covered person,* or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of this *policy*.

In addition, failure on the part of any *covered person,* or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid as soon as *we* receive proper *proof of loss*.

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to *you*. Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services, unless *you* provide other written direction no later than the time of filing *proof of loss*.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

FOREIGN CLAIMS INCURRED FOR EMERGENCY CARE: Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

ASSIGNMENT: *We* will reimburse a *hospital* or health care provider if:

A. *Your* health insurance benefits are assigned by *you* in writing; and

B. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under this *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

MEDICAID REIMBURSEMENT: The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:

A. A *covered person* is eligible for coverage under his or her state's Medicaid program; and

B. *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

CUSTODIAL PARENT: This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person,* will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

A. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of this *policy;*

B. Accept claim forms and requests for claim payment from the custodial parent; and

C. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

PHYSICAL EXAMINATION: *We* shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

LEGAL ACTIONS: No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under this *policy* for any reason unless the *covered person* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under this *policy*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

This provision does not apply to disputes concerning independent medical evaluations. Disputes concerning independent medical evaluations are subject to the Binding Arbitration for Independent Medical Evaluations provision below.

Binding Arbitration for Independent Medical Evaluations: If a *covered person* disagrees with the finding of an independent medical evaluation that *we* require, the *covered person* may appeal the decision through binding arbitration. Appeals for binding arbitration must be submitted to *us* within 30 days after the *covered person* receives the independent medical evaluation findings. All binding arbitration proceedings will follow the rules of the American Arbitration Association and all arbitration decisions are final.

COORDINATION OF BENEFITS

If benefits for *allowable expense* incurred during a *claim determination period* under this *policy*, together with benefits for *allowable expense* during the same *claim determination period* under all *other valid coverage* (without giving effect to this provision or to any *coordination of benefits provision* applying to *other valid coverage*), exceed the total of the *covered person's allowable expense* during the *claim determination period*, *our* liability will be only for the proportion of the benefits for *allowable expense* under this *policy* during the *claim determination period* as (a) the total *allowable expense* during the *claim determination period* bears to (b) the total amount of benefits payable during the *claim determination period* for the *allowable expense* under this *policy* and all *other valid coverages* (without giving effect to this provision or to any *coordination of benefits provision* applying to *other valid coverage*), less in both (a) and (b) any amount of benefits for *allowable expense* payable under *other valid coverage* that does not contain a *coordination of benefits provision*. The amount payable under this *policy* will not be greater than the amount that would have been payable in the absence of this provision.

We may pay benefits to the *other valid coverage* in the event of overpayment by the *other valid coverage*. Any such payment will fulfill *our* liability.

If *we* pay benefits to *you* or *your* beneficiary in excess of the amount that would have been payable if the existence of the *other valid coverage* had been known to *us*, *we* will have a right of action against *you* or *your* beneficiary to recover the excess amount.

When *other valid coverage* is on a service basis, the benefits payable will be the amount that the service rendered would have cost in the absence of the *other valid coverage*.

If this provision is applied to an *allowable expense*, *we* will also return to *you* any unearned premium *you* had paid prior to commencement of the *loss*, provided that the premium refund is 5 dollars or more.

Definitions: As used in this provision, the following terms have the meanings indicated:

"*Allowable expense*" means 100 percent of an expense that is covered, in whole or in part, under this *policy* or any *other valid coverage*.

"*Claim determination period*" means the 12-month calendar year. However, it does not include any part of a year during which a person has no coverage under this *policy*.

"*Coordination of benefits provision*" means any provision that may reduce an insurer's liability because of the existence of benefits under *other valid coverage*.

"*Other valid coverage*" means any plan or policy that provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses. This includes payment under individual coverages, including insurance policies, nonprofit health service plans, health maintenance organization subscriber contracts, prepaid limited health service organization plans, and Medicare when the *covered person* is enrolled in Medicare. *Other valid coverage* will not include Medicaid.

Section 13
GENERAL PROVISIONS

ENTIRE CONTRACT: This *policy,* with the application and/or enrollment form and any rider-amendments, is the entire contract between *you* and *us*. No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy*. No agent may:

A. Change this *policy;*

B. Waive any of the provisions of this *policy;*

C. Extend the time for payment of premiums; or

D. Waive any of *our* rights or requirements.

NON-WAIVER: If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of this *policy,* that will not be considered a waiver of any rights under this *policy*. A past failure to strictly enforce this *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

RESCISSIONS: No misrepresentation of fact made regarding a *covered person* during the application or enrollment process that relates to insurability or eligibility will be used to void/rescind the insurance coverage or deny a claim unless:

A. The misrepresented fact is contained in a written application or enrollment form, including amendments, signed by a *covered person;*

B. A copy of the application or enrollment form, and any amendments, has been furnished to the *covered person(s),* or to their beneficiary; and

C. The misrepresentation of fact was intentionally made and material to *our*

determination to issue coverage to any *covered person*.

A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: If *we* find that a *covered person* has performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of material fact, *we* have the right to demand that the *covered person* pay back all benefits *we* paid to *you* or the *covered person* incorrectly as a result of the *covered person's* actions, or paid in *your*/the *covered person's* name, during the time the *covered person* was insured under this *policy*.

UNIFORM MODIFICATION: *We* may modify *our* health insurance products effective January 1 of each calendar year, in accordance with state and federal law. If that action affects *your* plan, *we* will provide *you* with a new or modified plan.

CONFORMITY WITH STATE LAWS: Any part of this *policy* in conflict with the laws of the state where *you* reside on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

A. Identify the coverage, benefit, premium, or other disagreement;

B. Refer to the specific *policy* provision(s) at issue; and

C. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.