4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

San Francisco State University

GeoBlue Student

Certificate of Coverage Number: 4EL-1312-23

Effective Date: August 1, 2023

Policy Year: August 1, 2023 to July 31, 2024

This Certificate of Coverage describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern. The Certificate is issued by 4 Ever Life Insurance Company through a policy issued to the HTH Student Group Insurance Trust.

PRESIDENT SECRETARY

Table of Contents

I. Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Glossary section of your certificate.

This Certificate of Coverage, and any attached Riders, is issued by 4 Ever Life Insurance Company ("Insurer") through a policy issued to the HTH Student Insurance Trust. The Insurer will use a third party administrator to perform certain of its duties on its behalf. The Group and the Insured Participant are hereby notified of the use of Worldwide Insurance Services, LLC as its administrator.

4 Ever Life Insurance Company and Worldwide Insurance Services, LLC are Independent Licensees of the Blue Cross Blue Shield Association.

The benefits, limitations, exclusions and other coverage provisions in this certificate are subject to the terms of our contract with the Group. This certificate, and any attached Endorsements, are a part of that contract, which is on file in the Group's office and at Worldwide Insurance Services, LLC. This certificate replaces any other benefit certificate you may have received. The Group has delegated authority to Worldwide Insurance Services to use its expertise and judgment as part of the routine operation of the plan to reasonably apply the terms of the contract for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent you from exercising rights you may have under applicable state or federal law to appeal, have independent review of our judgment and decisions, or bring a civil lawsuit challenging to any eligibility or claims determinations under the contract, including our exercise of our judgment and expertise.

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services. Our provider networks include hospitals, physicians, and a variety of other types of providers.

This plan does not require use or selection of a primary care provider, or require referrals for specialty care. Subscribers may self-refer to providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

BlueCard® Program and Other Inter-Plan Arrangements

4 Ever Life Insurance Company and Worldwide Insurance Services/GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to non-network providers. Whenever you obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside our service area, you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

  Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

  - The billed covered charges for your covered services; or
  - The negotiated price that the Host Blue makes available to us.

  Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue to your healthcare provider. But sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers**

  Member Liability Calculation. When covered health care services are provided by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

  Exceptions. In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our network, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

  If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's services will be considered non-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on your ID card or go to www.geobluestudents.com for more information about such arrangements.

Providers available to you through the BlueCard Program have not entered into contracts with 4 Ever Life Insurance Company. If you have any questions or complaints about the BlueCard Program, please call us at the customer service telephone number listed on your ID card.

International/Foreign Country Providers
If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, Covered Expenses for these Foreign Country Providers are based on the Maximum Reimbursable Charge, if applicable, which may be less than actual billed charges. Foreign Country Providers can bill the Eligible Subscriber for amounts exceeding Covered Expenses. Worldwide Insurance Services provides a list to Eligible Subscribers of Foreign Country Providers with whom Worldwide Insurance Services has contracted to accept assignment of claims and direct payments from the Insurer or its Administrator for Covered Expenses incurred by Subscribers, thus alleviating the necessity of the Subscriber paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are not Participating Providers, but rather a group of Foreign Country Providers for whom Worldwide Insurance Services is able to provide background information and to arrange access for Subscribers.

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to 4 Ever Life and their Administrator for reimbursement. Out-of-Network and International claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim form at www.geobluestudents.com or from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to 4 Ever Life in care of their Administrator.

CLAIM REMINDERS
- BE SURE TO USE YOUR INSURANCE ID WHEN YOU FILE THE ADMINISTRATOR'S CLAIM FORMS, OR WHEN YOU CALL THE CUSTOMER SERVICE CENTER.
- YOUR MEMBER ID IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO THE ADMINISTRATOR.

Timely Filing of U.S. Out-of-Network & International Claims
4 Ever Life Insurance Company and its Administrator will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for U.S. Out-of-Network and International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for U.S. Out-of-Network and International benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

II. Eligibility, Effective Dates and Coverage Termination Dates

This section of your certificate describes who is eligible for coverage, what the effective date of your coverage is and when your coverage ends. We will use our expertise and judgment to reasonably construe the terms of this certificate as they apply to your eligibility for benefits.

Subscriber Eligibility
To be a subscriber under this plan, You must meet all of the following requirements:
1. You are in a Class of Eligible Subscribers; and
2. You pay any required premiums.

Classes of Eligible Participants
The following Classes of Subscribers are eligible for this insurance:
1. An international student, scholar, visiting faculty or other person with a current passport or non-immigrant visa, temporarily located outside his or her Home County as a non-resident alien and:
    a. Is engaged in educational activities of the Policyholder; and
    b. Has not obtained permanent residency status in the United States; and
    c. Is not a U.S. Citizen.

Except in the cases of a medical withdrawal due to Sickness or Injury, Subscribers must actively attend classes for at least the first 31 days of the period for which coverage is purchased, or the entire period for which coverage is purchased, whichever is the lesser. Participants withdrawing after such period will remain covered under the Policy for the term purchased and no refund will be allowed, except upon entry in the armed forces or as otherwise specified herein.

The Insurer maintains its right to investigate eligibility or student status and attendance records to verify that the eligibility requirements have been met. If the Insurer discovers that the eligibility requirements have not been met, its only obligation is to refund premium.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

This is a non-refundable policy. Enrollment cannot exceed 12 months.

Effective Date of Subscriber Insurance
Coverage begins 12:01 a.m. local time, if the eligibility requirements are met, on the later of:
1. The effective date reported as the term of coverage by the Policyholder or the Administrator, or the Administrator's authorized representative;
2. The date immediately following the date that full premium and completed application are received by the Policyholder; Administrator or the Administrator's authorized representative.

Coverage can begin on the date the Eligible Subscriber departs his or her Home Country, or country of regular domicile, traveling directly to the Policyholder sponsored program, provided such travel commences within 72 hours of the effective date of coverage for the then current term of which premium has been paid and travel is directly from the country of regular domicile to the Policyholder's location and such travel is no longer than 48 hours in length.

Coverage for any Eligible Subscriber cannot begin before the effective date of this Policy.

Thereafter, the insurance is effective 24 hours a day, worldwide.

Eligibility for Dependent Insurance
Eligible Subscribers may also enroll their Eligible Dependents on the date the Eligible Subscriber enrolls or within 31 days of birth, adoption, marriage, arrival in the United States or termination of other coverage (proof of date may be requested). The Eligible Dependent is one who:
1. Is traveling with the Eligible Subscriber on a similar passport or valid visa; and
2. Is temporarily located outside the Eligible Subscriber's Home Country as a non-resident alien; and
3. Has not obtained permanent resident status nor is a citizen of the United States.

An Eligible Dependent may be the Eligible Subscriber's:
1. Legally married spouse of the same or opposite sex;
2. Unmarried dependent children under the age of 26. The term "Children" includes an Eligible Subscriber's biological children, stepchildren and adopted children from the date of placement;
3. own or spouse's unmarried child, of any age, enrolled prior to age 26, who is incapable of self-support due to continuing mental or physical disability and who is chiefly dependent on the Eligible Subscriber spouse. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 26th birthday and annually thereafter.

Effective Date of Dependent Insurance
For your Dependents to be insured, you will have to pay the required premium, toward the cost of Dependent Insurance. Insurance for your Dependents will become effective on the date you elect it by signing an approved enrollment form (if required) and premium are received by the Policyholder, the Administrator or the Administrator's authorized agent.

Your Dependents will be insured only if you are insured.

Dependent Coverage will not be effective prior to that of the Eligible Subscriber or extend beyond that of the Eligible Subscriber.

Exception for Newborns
Any Dependent child born while you are insured will become insured on the date of their birth if you elect Dependent Insurance no later than 31 days after their birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. Please see the Newborn Care in the Covered Expenses section of this certificate.

If the mother is not eligible to receive obstetrical care benefits under this plan, the newborn isn't automatically covered for the first 31 days.

Plan benefits and provisions will apply, subject to the child's own applicable copay, policy year deductible and coinsurance requirements.

Effective Termination Date of Subscriber Insurance
Coverage will end at 11:59 p.m. on the earliest of the following dates for the Eligible Subscriber:
1. The date the Policy is terminated by the Policyholder or the Insurer;
2. The last day of the Term of Coverage for which premium is paid;
3. The date the Eligible Subscriber permanently returns to his/her or her Home Country;
4. The date the Eligible Subscriber no longer meets the eligibility requirements;

An Eligible Participant's coverage will end without prejudice to any claim existing at the time of termination.

There is no continuation of coverage for this plan for Eligible Participants who are no longer eligible.

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation
If the Medical Benefits under this plan cease for the Eligible Participant due to cancellation of the policy (except if policy is canceled for nonpayment of premiums) and the Eligible Participant is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:
- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date the Eligible Subscriber is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when the Medical Benefits cease for the Eligible Participant.

Important Information About Your Medical Plan
Details of your medical benefits are described on the following pages.

III. Schedule of Benefits

This section of the certificate explains the types of expenses You must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it is important for you to understand what you are responsible for.

Coinsurance
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Exception: Coinsurance will not apply to services provided by the Recognized Student Health Center.

Copayments/Deductibles
Copayments, or Copays, are expenses to be paid by each Eligible Subscriber for covered services. Deductibles are also expenses to be paid by each Eligible Subscriber. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Exception: Deductibles and/or Copay will not apply to services provided by the Recognized Student Health Center.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance
- Plan Deductible
- Copayments
- Prescription Drug Copayments

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Provider charges in excess of the Maximum Reimbursable Charge.
- Non-compliance penalties
- Non-allowed charges

Accumulation of Plan Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Maximums will cross-accumulate between In-Network and Out-of-Network. All other plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

Multiple Surgical Reduction
Multiple and/or bilateral surgical services rendered by the same professional provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50%.

Procedures performed in conjunction with the primary surgical procedure considered by the Insurer to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures are defined as procedures requiring little additional provider resources and/or are clinically integral to the performance of the primary procedure.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to charges made by an assistant surgeon as specified in 4 Ever Life or its Administrator's reimbursement policies.

Co-Surgeon
The maximum amount payable will be limited to charges made by co-surgeons as specified in 4 Ever Life or its Administrator's reimbursement policies.

Metal Value: Platinum
Actuarial Value: 92.91

Benefit Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	100%	50% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentage of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.		
Policy Year Deductible		
Individual	$250	$250
Family Deductible	2 times the Individual Deductible	2 times the Individual Deductible
Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximum		
Individual	$5,000	$5,000
Family Maximum	2 times the Individual Out-of-Pocket Maximum	2 times the Individual Out-of-Pocket Maximum
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Physician's Services		
Physician's Office Visit - Primary Care Physician	100%, No Deductible, $10 copay	50% after plan deductible
Office Visit – Specialist	100%, No Deductible, $10 copay	50% after plan deductible
Surgery Performed In the Physician's Office	100% after plan deductible	50% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	100%, No Deductible, $10 copay	50% after plan deductible
Allergy Treatment/Injections	100%, No Deductible, $10 copay	50% after plan deductible
Preventive Care Routine Preventive Care – all ages	100% not subject to plan deductible or copayments	50% after plan deductible
Immunizations – all ages	100% not subject to plan deductible or copayments	50% after plan deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to plan deductible or copayments	50% after plan deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to plan deductible or copayments	50% after plan deductible
Inpatient Hospital – Facility/Professional Charges		
Room and Board Charges	100% after plan deductible	50% after plan deductible
Physician's Visits/Consultations	100% after plan deductible	50% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% after plan deductible	50% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
Inpatient Services at Other Heath Care Facilities		
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	100% after plan deductible	50% after plan deductible
Policy Year Maximum of 120 day limit.		
Ambulatory Surgical Services		
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	100% after plan deductible	50% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% after plan deductible	50% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Hospital Emergency Room	100% after plan deductible Additional $250 copay per visit – waived if admitted	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate. Additional $250 copay per visit – waived if admitted
Outpatient Professional Services (radiology, pathology and ER Physician)	100% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Urgent Care Facility	100% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	100% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	100% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Ambulance	100% after plan deductible	50% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Laboratory and Radiology Services (includes pre-admission testing)		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Independent X-ray and/or Lab Facility	100% after plan deductible	50% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Independent Facility	100% after plan deductible	50% after plan deductible
Maternity Care/Obstetrical Services		
Physician's Office visit to confirm pregnancy	100%, No Deductible, $10 copay	50% after plan deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	100% after plan deductible	50% after plan deductible
Physician's Office visits in addition to the global maternity fee	100%, No Deductible, $10 copay	50% after plan deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	100% after plan deductible	50% after plan deductible
Delivery Charges – Facility (Hospital, Birthing Center)	100% after plan deductible	50% after plan deductible
Termination of Pregnancy		
Medically Necessary	100% after plan deductible	50% after plan deductible
Elective	100% after plan deductible	50% after plan deductible
Infertility Expenses – Basic Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Family Planning/Contraception Management See benefit description for specific coverages For Women		
Physician's Office Visit	100% not subject to plan deductible or copayments	50% after plan deductible
Inpatient Facility	100% not subject to plan deductible or copayments	50% after plan deductible
Outpatient Facility	100% not subject to plan deductible or copayments	50% after plan deductible
Physician's Services	100% not subject to plan deductible or copayments	50% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
For Men		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Obesity/Bariatric Surgery		
Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese.		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Organ Transplant Services		
Includes all medically appropriate, non-experimental transplants.		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	100% after plan deductible	Not Covered
Transgender Services		
See benefit description for covered services.		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Nutritional Evaluation		
Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Nutritional Formulas	100% after plan deductible	50% after plan deductible
Acupuncture Physician's office visit	100%, No Deductible, $10 copay	50% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
Chiropractic Care/Spinal Manipulations Physician's office visit	100%, No Deductible, $10 copay	50% after plan deductible
Telehealth	100%, No Deductible, $10 copay	50% after plan deductible
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an injury		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
TMJ Treatment	100% after plan deductible	50% after plan deductible
Diabetic Equipment	100% after plan deductible	50% after plan deductible
Durable Medical Equipment	100% after plan deductible	50% after plan deductible
External Prosthetic Appliances	100% after plan deductible	50% after plan deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	100% after plan deductible	50% after plan deductible
Mental Health		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Substance Abuse Health		
Inpatient Facility	100% after plan deductible	50% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Outpatient Facility	100% after plan deductible	50% after plan deductible
Hearing Benefit One Examination per 24 month period	100%, No Deductible, $10 copay	50% after plan deductible
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 24 months	100% after plan deductible	50% after plan deductible
Home Health Care Services Policy Year Maximum of 120 visit limit	100% after plan deductible	50% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
Private Duty Nursing Policy Year Maximum of 120 visit limit	100% after plan deductible	50% after plan deductible
Hospice Care Services	100% after plan deductible	50% after plan deductible
Infusion Therapy		
Outpatient Facility	100% after plan deductible	50% after plan deductible
Physician's Services	100% after plan deductible	50% after plan deductible
Short Term Rehabilitative Therapy		
Physician's Office Visit	100%, No Deductible, $10 copay	50% after plan deductible
Outpatient Hospital Facility	100% after plan deductible	50% after plan deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.		

Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for all Eligible Subscribers. The plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the schedule and as described in the Prescription Drug Coverage section of this certificate. To receive Prescription Drug Benefits, the Eligible Subscriber may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments as may be applicable. Benefits are limited as described in the Prescription Drug section of this certificate and are subject to the Medical "Exclusions" section of this certificate.

Benefit Highlights	Participating Pharmacy	Non-Participating Pharmacy
Retail Prescription Drugs	Cost per 30-day Supply	Cost per 30-day Supply
	Certain medications as part of preventive care services are covered at 100% with no cost sharing either through a retail drug store. Detailed information is available at www.healthcare.gov	
Generic*	$20 Copayment, deductible does not apply	$20 Copayment, deductible does not apply
Brand-Name*	$50 Copayment, deductible does not apply	$50 Copayment, deductible does not apply
Non – Formulary*	$50 Copayment, deductible does not apply	$50 Copayment, deductible does not apply
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

IV. Covered Expenses Benefit Description

This section of your certificate describes the specific benefits available for covered services and supplies. Benefits, subject to the copayments, coinsurance, deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements:

1. It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury;
2. It must be medically necessary (please see the "Glossary" section in this certificate) and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive;
3. It must not be excluded from coverage under this plan;
4. The expense for it must be incurred while you are covered under this plan and after any applicable waiting period required under this plan is satisfied;
5. It must be furnished by a "provider" (please see the "Glossary" section in this certificate) who's performing services within the scope of his or her license or certification;
6. It must meet the standards set in our medical and payment policies. Our policies are used to administer the terms of the plan. Medical policies are generally used to determine if a Subscriber has coverage for a specific procedure or service. Payment policies define billing and provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA).

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions throughout this section and the "Exclusions, Expenses Not Covered and General Limitations" section for a complete description of covered services and supplies, limitations and exclusions. **Any applicable Copayments, Deductibles or limits are shown in the Schedule of Benefits.**

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of Eligible Subscriber's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- Charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
  - 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;
  - 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 the Covered Person involved;
  - for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  - for women, such additional preventive care and screenings not described in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Charges made for or in connection with mammograms including; a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for a-symptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- Surgical or nonsurgical treatment of TMJ dysfunction.
- Charges made for or in connection with one baseline lead poison screening test for Dependent children, if covered, at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children, if covered, under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- Charges made for children from birth through age 18, if covered, for immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; Haemophilus influenzae B; and hepatitis A, and any new vaccines recommended by United States Preventive Task Force Services.

- Charges made for U.S. FDA approved prescription contraceptive drugs and devices and for outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.
- Charges made for Diabetic supplies as recommended in writing or prescribed by a Participating Physician or Other Participating Health Care Professional, including insulin pumps and blood glucose meters.
- Scalp hair prostheses worn due to alopecia areata or due to hair loss resulting from cancer treatment.
- Colorectal cancer screening for persons 50 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of hereditary nonpolyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is medically necessary in the judgment of the treating Physician.
- Hearing aids for Dependent children (if covered) up to age twenty-six (26).
- Nutritional formulas, low protein modified food products, or other medical food consumed or administered enterally (via tube or orally) which are medically necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician.
- The treatment of autism spectrum disorder for the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.
- Charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.

Acupuncture

Benefits for acupuncture services received in a provider's office when you see a provider, are subject to the copay and visit limitations as stated in the Schedule of Benefits. Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Ambulance Services

Benefits for the following services are subject to your policy year deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the person that requires transportation.

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Chiropractic Care Services/Spinal Manipulations

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements: The study or investigation must:

- Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- Involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- Services required solely for the provision of the investigational drug, item, device or service;
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service;
- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
- Routine patient care costs (as defined) for covered persons engaging in clinical trials for treatment of life threatening diseases.

Routine patient care costs do not include:

- The investigational drug, item, device, or service, itself; or
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- There are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- The clinical trial is conducted outside the individual's state of residence.

Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

The Plan covers:

- Charges made by a physician, a dentist and hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- General anesthesia and related facility services for dental procedures are covered when medically necessary for 1 of 2 reasons:
  - The Subscriber is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
  - The Subscriber has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - As a result of an Injury to natural teeth damaged, lost or removed; or
  - Other body tissues of the mouth fractured or cut due to injury.
  - Any such teeth must have been free from decay or in good repair, and be firmly attached to the jaw bone at the time of the injury.

  If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food. The treatment must be completed within 12 months of the injury.

Durable Medical Equipment

Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Insurer for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath Related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Special or extra-cost convenience features;
- Structural modifications to your home or personal vehicle;
- Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities;
- Penile prostheses;
- Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; splints; and medical vision hardware.

Prostheses/prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Medical Vision Hardware
Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

Family Planning and Contraceptive Management

Benefits for sterilization and for contraceptive management are covered as shown in the Schedule of Benefits. Coverage differences apply to men and women.

This benefit covers the following services and supplies received from a health care provider:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility charges will be subject to your cost-shares under the applicable facility benefit and are not covered by this benefit.

Contraceptives Dispensed By a Pharmacy

- Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the Prescription Drugs benefit. For women, the normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when you get them from a participating pharmacy.

  Examples of covered devices are diaphragms and cervical caps.

- Over-the-counter female contraceptives that are prescribed by your healthcare provider and purchased through a licensed pharmacy are also covered. No cost-share is required when you get them through a participating pharmacy.

The Contraceptive Management and Sterilization benefit doesn't cover:

- Over-the-counter male contraceptive drugs, supplies or devices
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.)
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- A person has symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Home Health Care Services

Home health care must be preauthorized.

Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan and provided you are:

- Transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay; or
- Homebound

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when:
  - It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
  - It is ordered by a physician;
  - It is not delivered for the purpose of assisting with activities of daily living, including but not limited to, dressing, feeding, bathing or transferring from a bed to a chair; and
  - It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened if you are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals.

Four hours = one visit; the Plan allows up to three visits per date of service (the maximum number of hours per day is 12 hours).

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the maximum visits, each visit of up to four hours is one visit. This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are not met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Home Health Care Limits

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

The Plan does not cover Custodial Care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to your Summary of Medical Benefits for details about any applicable home health care visit maximums.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

Hospice Care Services

Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.
- Up to three (3) bereavement sessions, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Subscriber's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, stepchildren, parents, and siblings.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of the Eligible Subscriber's family or who normally resides in the Eligible Subscriber's house;
- for any period when an Eligible Subscriber is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid the Eligible Subscriber in daily living.

Hospital Inpatient Care

Benefits are provided for the following inpatient medical and surgical services:

- Semi-Private Room and board expenses, including general duty nursing and special diets

  Note: When outside the United States, benefit will provide coverage for private rooms if that is all that is available or if the choice is between a ward or a more than two person room and a private room.

- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards.
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen.
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration.
- Parental Accommodation – if charged by a hospital, charges for one parent or legal guardian to stay in a hospital with a covered child under the age of 12.

For inpatient hospital substance abuse treatment, please see the Mental Health and Substance Abuse Services benefit description.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless Your medical condition makes inpatient care medically necessary.
- Any days of inpatient care that exceeds the length of stay that is medically necessary to treat your condition.

Infertility Services

Basic Infertility Expenses

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

Infusion Therapy

Covered expenses include charges made on an outpatient basis for infusion therapy if the rendering provider's bill includes fees for both medication and administration and if the services are provided by:

- A free-standing facility;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

When you obtain infusion therapy medications from a pharmacy or if they are not billed by your provider along with the therapy administration fee, you should submit your claims for medications under the prescription drug benefits, rather than the medical benefits.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under the Plan's inpatient hospital and skilled nursing facility benefits.

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Maternity Care/Obstetrical Services

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for the subscriber or enrolled spouse. However, complications of pregnancy are covered on the same basis as any other illness for the subscriber, enrolled spouse, or enrolled dependent child.

Preventive diagnostic services that meet the guidelines for preventive care are covered for all Eligible Subscribers as stated in the Preventive Care benefit.

Inpatient Hospital Services
Benefits for these services are shown in the Schedule of Benefits.

Birthing Center and Short-Stay Hospital Facility Services
Benefits for these services are shown in the Schedule of Benefits.

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Plan benefits are also provided for medically necessary supplies related to home births.

Benefits for the following obstetrical care services are covered as shown in the Schedule of Benefits.

1. Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
2. Delivery, including cesarean section, in a medical facility, or delivery in the home
3. Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Schedule of Benefits for details.

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services
Services that are provided by a Hospital while the Eligible Subscriber is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services
Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while the Eligible Subscriber is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.
A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services
Services provided for rehabilitation, while the Eligible Subscriber is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24- hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services
Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while the Eligible Subscriber is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services
Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Insurer will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions
The following are specifically excluded from Mental Health and Substance Abuse Services:

- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature; for borderline intellectual functioning; occupational problems; counseling related to consciousness raising; and for vocational or religious counseling.
- Any costs associated with voluntary support groups, such as Al-anon or Alcoholics Anonymous.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care, and halfway houses, quarterway houses, recovery houses, and other sober living residences.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Newborn Care
Newborn children are covered automatically for the first 31 days from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 31 day period, please see the eligibility and enrollment guidelines outlined in the "Eligibility, Effective Dates and Coverage Termination Dates" section.

If the mother is not eligible to receive obstetrical care benefits under this plan, the newborn isn't automatically covered for the first 31 days. For newborn enrollment information, please see the "Eligibility, Effective Dates and Coverage Termination Dates" section.

Plan benefits and provisions will apply, subject to the child's own applicable copay, policy year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care
Benefits for these services are subject to your policy year deductible and coinsurance when you use a facility.

The Newborn Care benefit covers hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Professional Care
Benefits for services received in a provider's office are subject to the terms of the Professional Visit benefit. Well-baby exams in the provider's office are covered under the Preventive Care benefit. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

Inpatient Professional Care
Benefits for these services are subject to your policy year deductible and coinsurance when services are provided by a provider.

Outpatient Professional Visits
You pay the copay as stated in the Schedule of Benefits per visit in an office setting when you use a provider.

When you see a provider outside an office setting, benefits are subject to your policy year deductible and coinsurance.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician’s assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

This benefit does not cover immunizations and outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and outpatient well-baby exams.

Nutritional Evaluation
Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Obesity Treatment
Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam; or
- Diagnostic tests given or ordered during the first exam

The Plan covers inpatient or outpatient charges made by a hospital or a physician for the medically necessary surgical treatment of Morbid Obesity. Bariatric surgery must be approved in advance by claims administrator.

Covered expenses include one morbid obesity surgical procedure within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

The Plan does not cover

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- bariatric surgery when done for cosmetic reasons; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Organ Transplants Services
The Transplants benefit is not subject to a separate benefit maximum other than the maximums for transport and lodging and for donor costs described below. This benefit covers medical services only if provided by providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the "Glossary" section in this certificate for the definition of "experimental/investigational services.") We reserve the right to base coverage on all of the following:

Organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

- Your medical condition must meet our written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

If none of Our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

The following services are included in the Transplant Services benefits:

- **Inpatient Facility Services** – Benefits for services in a facility or an approved transplant center are subject to your Policy Year deductible and coinsurance.
- **Inpatient Professional and Surgical Services** – Benefits for a provider or an approved transplant provider are subject to your Policy Year deductible and coinsurance.
- **Outpatient Surgical Facility Services** – Benefits for a facility or an approved transplant center are subject to your Policy Year deductible and coinsurance.

- **Outpatient Professional Visits** – You pay the copay as stated in the Schedule of Benefits per visit in an office setting to a provider or an approved transplant provider. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this certificate for details about this copay.

  When a professional visit isn't provided in an office setting, benefits are subject to your in-network Policy Year deductible and coinsurance.

- **Other Outpatient Professional Services** – Benefits for a provider or an approved transplant provider are subject to your Policy Year deductible and coinsurance.

- **Transport and Lodging** – The transport and lodging benefits are subject to your deductible, but aren't subject to your coinsurance.

  Reasonable and necessary expenses for transportation and lodging for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:
  - The transplant recipient must reside more than 50 miles from the approved transplant center unless medically necessary treatment protocols require the Subscriber to remain closer to the transplant center.
  - The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
  - When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided.
  - When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided.
  - Covered transportation and lodging expenses incurred by the transplant recipient and companions are limited to a one room, double occupancy. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

- **Recipient Costs** – This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

- **Donor Costs –** Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

This benefit doesn't cover:
- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a Subscriber.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the "Glossary" section in this certificate).
- Personal care items.
- Under the Transportation and Lodging benefit, expenses for travel within 50 miles from your home, laundry bills, mobile phone charges, charges for alcohol or tobacco products, or transportation charges that exceed coach class rates.
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future.

Orthognathic Surgery
Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Private Duty Nursing
Covered expenses include private duty nursing provided by an R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a calendar year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to eight hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or emergency medical condition by a physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient stay.

Private Duty Nursing Limits

Unless specified above, not covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of an R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility, provided the care can adequately be provided by the facility's general nursing staff, if it were fully staffed.
- A service provided solely to administer oral medicine, except where law requires an R.N. or L.P.N. to administer medicines.

Reconstructive Surgery

Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient’s current status.

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Telehealth

This Policy provides benefits for covered services that are appropriately provided through Telehealth, subject to the terms and conditions of the Policy. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

Equipment costs and transmission costs associated with Telehealth are not reimbursable.

Temporomandibular Joint (TMJ) Disorders

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this plan.

This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits.

Medical and dental services and supplies are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good medical or dental practice.
- Not experimental or investigational, as determined by us according to the criteria stated under "Glossary," or primarily for cosmetic purposes.

Transgender Services

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the policy that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to Policy benefits that apply to that type of service generally, if the policy includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the policy's prescription drug benefits.

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided.

V. Pediatric Vision and Dental Care

Vision Services for Insured Subscribers through Age 18

The vision benefits described in this section only apply to Insured Subscriber through age 18. Vision services covered through this benefit will not be covered through any other benefit listed in this Plan, and are not subject to the Medical Plan annual deductible or coinsurance, but rather to the separate copayments listed in the Vision Services Schedule of Benefits listed below.

The services and benefits covered are as follows:

- **Routine eye exams.** Complete eye exam, with dilation, as needed.
- **Eyeglass lenses.** Coverage includes factory scratch coating, UV coating, and polycarbonarte and photochromic lenses. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in single vision, bifocal, trifocal (FT 25-28), and progressive lenses.
- **Frames.** You must choose a frame from our formulary.
- **Contact lenses.** The following benefits are provided:
  - Elective contact lenses (those chosen for comfort or appearance rather than medical need).
  - Non-elective contact lenses for the following medical conditions only:
    - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    - High Ametropia exceeding -12D or +9D in spherical equivalent.
    - Anisometropia of 3D or more.
    - Aniridia.
    - Aphakia for Eligible Subscribers through age 9.
    - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

  Special Note: Benefits are not available for non-elective contact lenses if you have undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or laser eye correction surgery such as LASIK.

  Except for the conditions aniridia and aphakia, fitting and dispensing of contact lenses is not a covered benefit and will be at an additional cost to the Eligible Subscriber.

  This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit year, no benefits will be available for eyeglass lenses until the next Benefit year. If you choose eyeglass lenses during a Benefit year, no benefits will be available for contact lenses until the next Benefit year.

- Low vision. Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the remaining usable vision for *insured persons* with low vision. Low vision benefits include:
  - Comprehensive Low Vision Exam
  - Optical/Non-optical aids
  - Supplemental testing

Pediatric Vision Care Schedule of Benefits

Service or Item Covered	Eligible Subscriber Benefit
• Routine Eye Exam Limited to one exam per Policy year	100% of the Maximum Reimbursable Charge
• Standard Plastic Lenses Limited to one set of lenses once per Policy year. Available only if the contact lenses benefit is not used.	
Single Vision	100% of the Maximum Reimbursable Charge
Bifocal	100% of the Maximum Reimbursable Charge
Trifocal	100% of the Maximum Reimbursable Charge
Progressive	100% of the Maximum Reimbursable Charge
Note: lenses include factory scratch coating and UV coating at no additional cost. Standard polycarbonate and standard photochromic lenses are also covered at no extra cost.	

Service or Item Covered	Eligible Subscriber Benefit
• Frames Limited to one set of frames once per Policy year and limited to a Maximum benefit of $200 Frames costing in excess of $200	100% of the Maximum Reimbursable Charge 60% of the Maximum Reimbursable Charge
• Contact Lenses (formulary) A one-year supply is covered every Policy year (applicable to certain contact lenses within the Insurer's formulary). Available only if the eyeglass lenses benefit is not used. Except as stated for aniridia and aphakia, fitting and dispensing of contact lenses is not a covered benefit and will be at an additional cost to the Eligible Subscriber.	
Elective Contact Lenses (Conventional or Disposable)	100% of the Maximum Reimbursable Charge
Non-Elective Contact Lenses, including special contact lenses for the treatment of: – Aniridia. Limited to two contact lenses per eye (includes fitting and dispensing) per Policy year. – Aphakia (for Eligible Subscribers through age 9. Limited to six aphakic contact lenses per eye (includes fitting and dispensing) per Policy year.	100% of the Maximum Reimbursable Charge
• Low Vision	
– Comprehensive low vision exam. Limited to one exam every five Policy year.	100% of the Maximum Reimbursable Charge
– Optical / non-optical aids and supplemental testing. Limited to one occurrence of either optical / non-optical aids or supplemental testing per Policy year.	100% of the Maximum Reimbursable Charge

Dental Services for Insured Scribers through Age 18

The dental services described in this section only apply to Eligible Subscribers through age 18. Dental services covered through this benefit will not be covered through any other benefit listed in this plan. This Plan covers the dental services below for Eligible Subscribers through age 18 when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Dental services covered through this benefit will not be covered through any other benefit listed in this Plan, and are not subject to the Medical Plan annual deductible or coinsurance, but rather to the separate deductible and coinsurance listed in the Dental Services Schedule of Benefits listed below.

A preset schedule of dental care services is covered under this Plan. We evaluate the procedures submitted to us on claims to determine if they are a covered service under this Plan, Claims for orthodontic care will be reviewed to determine if it was dentally necessary orthodontic care.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible that may apply. The decision as to what dental care treatment is best for you is solely between you and your dentist.

Coinsurance

As used in this plan, "coinsurance" is a defined percentage of charges for covered services and supplies you receive. The percentage you're responsible for is called "coinsurance."

Deductibles

Deductibles are expenses to be paid by an Eligible Subscriber. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Benefit Percentages

After you satisfy the required deductible if one applies, you pay the following coinsurance per Policy. Dental services fall into 4 categories: Diagnostic and Preventive services, Basic services, Major services and Orthodontic services. In this section you'll find a description of the services included in each category.

Pediatric Dental Care Schedule of Benefits

• Per Person Policy Year Dental Deductible Not applicable to Diagnostic and Preventive Services	$500
• Diagnostic and Preventive Services	100% of the Maximum Reimbursable Charge
• Basic Services	70% of the Maximum Reimbursable Charge
• Major Services	50% of the Maximum Reimbursable Charge
• Orthodontic Services	50% of the Maximum Reimbursable Charge

Description of Covered Services

Covered Services

The following section lists covered dental services. We may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Us.

Diagnostic and Preventive Services

- Routine oral examinations are limited to 2 per policy year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations.
- Emergency oral examinations. (Please see the "Definitions" section for the definition of a Dental Emergency.) Services that are determined to be routine will be limited to 2 per policy year.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per policy year
- Topical application of fluoride is covered for Subscribers through age 18. They're limited to 2 treatments per policy year.
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.
- Bitewing x-rays – Only 2 charges per person per policy year.
- Space maintainers, for Subscribers through age 18.
- Sealants, for Subscribers through age 18, are limited to use on permanent teeth
- Oral pathology laboratory services, not including the removal of tissue sample, is covered when directly related to teeth and gums

Basic Services

- Simple extractions
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses
- Dentally necessary injectable drugs administered in a dental office
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance.
- Stainless steel crowns are limited to one per tooth every 2 calendar years
- Non-surgical treatment of periodontal and other diseases of the gums and tissues of the mouth:
- Periodontal scaling and root planing and sub-gingival curettage is limited to a total of 2 full-mouth treatments in any 12 consecutive months.
- Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 4 visits per calendar year.
- Repair and re-cementing of crowns, inlays, bridgework and dentures
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- General anesthesia in a dental care provider's office, when dentally necessary. This includes Subscribers who are under the age of 7 or are disabled physically or developmentally.
- Osseous surgery, which includes gingivectomy, gingivoplasty, and gingival flap procedures
- Endodontic (root canal) treatment:
- Benefits for root canals performed in conjunction with over-dentures are limited to 2 per arch
- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
- X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional x-rays are limited to the allowance for the root canal therapy.

Major Services

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings wouldn't adequately restore the teeth.
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
  - The existing restoration was seated at least 5 years before replacement; or
  - The service is a result of an injury as described under "Dental Care Services For Injuries"
- Occlusal guards, for bruxism (grinding) only. Limited to 1 every 3 rolling years.
- Initial placement of dentures
- Initial placement of fixed bridgework (including inlays, onlays and crowns to form abutments)
- Replacement dentures and fixed bridgework, but only when:
  - The existing denture or bridgework was installed at least 5 years before replacement;
  - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement; or
  - Re-preparation of the natural tooth structure under the existing fixed bridgework is required as a result of an injury to that structure, and such repair is performed within 12 months of the injury.
- Relining and rebasing of dentures when performed 6 or more months after denture installation. Charges for relines, rebases and adjustments performed during the first 6 months following denture installation are limited to the allowance for the denture.
- Tooth build-ups for covered onlays and crowns, including bridge abutments
- Implants and implant-related services
  Note: Covered services including implant abutment and/or crowns over the implants are covered only once in a 5-consecutive year period (5 years from the date of the installation of the prosthetic service).
- Precision attachments

Orthodontic Services

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Dentally necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered dentally necessary orthodontic care, at least one of the following must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items (a) through (d) above, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us to find out if it will be covered under this *plan*.

Benefits may include the following:

- Limited treatment. Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive treatment. A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) treatment. Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable appliance therapy. An appliance that is removable and not cemented or bonded to the teeth.
- Fixed appliance therapy. A component that is cemented or bonded to the teeth.
- Other complex surgical procedures. Surgical exposure of impacted or un-erupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated maximum allowed amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your *Plan* benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Expenses Not Covered

This section of your booklet explains circumstances in which benefits of this plan are limited or not available. Benefits can also be affected by your eligibility. Some benefits may also have their own specific limitations.

Limited and Non-Covered Services

In addition to the specific limitations stated elsewhere in this plan, this plan doesn't cover:

1. **Benefits From Other Sources -** Benefits aren't available under this plan when coverage is available through:
   a. Motor vehicle medical/dental or motor vehicle no-fault
   b. Personal injury protection (PIP) coverage
   c. Commercial liability coverage
   d. Homeowner policy
   e. Other types of liability insurance
   f. Worker's Compensation or similar coverage
2. **Benefits That Have Been Exhausted -** Amounts that exceed the maximum benefit for a covered service.
3. **Broken Appointment Charges -** Amounts that are billed for broken or late appointments.
4. **Charges For Records Or Reports -** Separate charges from providers for supplying records or reports, except those we request for utilization review.
5. **Cosmetic Services**
   a. Treatment of congenital malformations, except when the patient is an eligible dependent child.
   b. Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof. This exclusion doesn't apply to services and supplies covered under the Orthodontia benefit, if this plan includes that benefit.
6. **Dental Services Received From a:**
   a. Dental or medical department maintained for employees by or on behalf of an employer; or
   b. Mutual benefit association, labor union, trustee, or similar person or group.
7. **Dietary Services -** Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.
8. **Experimental Or Investigational Services -** Any service or supply that the Insurer determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Glossary" section in this certificate).

   If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "When You have a Complaint or an Appeal?" section in this booklet for an explanation of the appeals process.
9. **Extra Or Replacement Items -** Extra dentures or other appliances, including replacements due to loss or theft.
10. **Facility Charges -** Hospital and ambulatory surgical center care for dental procedures.
11. **Family Members Or Volunteers**
    a. Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child.
    b. Services or supplies provided by volunteers
12. **Home-Use Products -** Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
13. **Increase Of Vertical Dimension -** Any service to increase or alter the vertical dimension.
14. **Military And War-Related Conditions, Including Illegal Acts -** This includes:
    a. Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
    b. A Subscriber's commission of an act of riot or insurrection
    c. A Subscriber's commission of a felony or act of terrorism
15. **Multiple Providers -** Services provided by more than one dental care provider for the same dental procedure.

16. **No Charge Or You Don't Legally Have To Pay**
    a. Services for which no charge is made, or for which none would have been made if this plan weren't in effect
    b. Services for which you don't legally have to pay, unless benefits must be provided by law
17. **Non-Standard Techniques -** Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.
18. **Not Covered Under This Plan**
    a. Services that aren't listed in this booklet as covered or that are directly related to any condition, service or supply that isn't covered under this plan.
    b. Services received or ordered when this plan isn't in effect, or when you're not covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Major services and root canals that:
        - Were started after your effective date and before the date your coverage ended under this plan; and
        - Were completed within 30 days after the date your coverage ended under this plan.

        The following are deemed service start dates:
        - For root canals, it's the date the canal is opened.
        - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the preparation date.
        - For partial and complete dentures, it's the impression date.

        The following are deemed service completion dates:
        - For root canals, it's the date the canal is filled.
        - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the seat date.
        - For partial and complete dentures, it's the seat or delivery date.
19. **Not Dentally Necessary -** Services that aren't dentally necessary (see definition of "Dentally Necessary").
20. **Orthodontia Services -** Orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers are only covered under the Orthodontia benefit, if this plan includes that benefit. This exclusion doesn't apply to extractions incidental to orthodontic services.
21. **Oral Surgery** for the following procedures:
    a. surgical services related to a congenital malformation;
    b. surgical removal of complete bony impacted teeth;
    c. excision of tumors or cyst of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.
22. **Orthognathic Surgery (Jaw Augmentation or Reduction) -** Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.
23. **Outside The Scope Of A Provider's License Or Certification -** Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.
24. **Prescription Drugs -** Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.
25. **Temporomandibular Joint (TMJ) Disorders -** Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and after effects thereof.
26. **Testing And Treatment Services -** Testing and treatment for mercury sensitivity or that are allergy-related.
27. **Work-Related Conditions -** Any illness, condition or injury arising out of or in the course of employment, for which the Subscriber is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
    a. Occupational coverage required or voluntarily obtained by the employer;
    b. State or federal workers' compensation acts; or
    c. Any legislative act providing compensation for work-related illness or injury.

    However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

VI. Prescription Drug Benefits

Covered Expenses
If an Eligible Subscriber, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, the Insurer will provide coverage for those expenses as shown in the Schedule of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to an Eligible Subscriber by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Prescription Drug Conditions of Service
To be covered, the drug or medication must satisfy all of the following requirements:
1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your covered illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered.
    a. Formulas prescribed by a physician for the treatment of phenylketonuria.
    b. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.
5. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.
6. For a retail pharmacy, the prescription must not exceed a 30-day supply.

You will always be responsible for expense incurred which is not covered under this Plan.

Your Payments
Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy may be subject to a Deductible, Copayment or Coinsurance. Please refer to the Schedule of Benefits for any required cost sharing or maximums if applicable.

Prescription Drug Services and Supplies that ARE Covered
1. Outpatient drugs and medications which the law restricts to sale by prescription, except as specifically stated in this section. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copayment for brand name drugs.
2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable drugs or medications.
4. Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs with Food and Drug Administration (FDA) labeling for self-administration.
5. All compound prescription drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA approved, a prescription to dispense is required, and the compound drug is not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
6. Certain medications as part of preventive care services are covered at 100% with no cost sharing either through a retail drug store or through mail order. Detailed information is available at www.healthcare.gov
7. Diabetic supplies (i.e. test strips and lancets).
8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for brand name drugs.

Prescription Drug Services and Supplies that ARE NOT Covered

In addition to the exclusions and limitations listed under "Exclusions, Expenses Not Covered and General Limitations", Prescription Drug benefits are not provided for or in connection with the following:

1. Immunizing agents, biological sera, blood, blood products or blood plasma.
2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable drugs or medications.
3. Drugs and medications used to induce spontaneous and non-spontaneous abortions.
4. Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient hospital facilities and physicians' offices.
5. Professional charges in connection with administering, injecting or dispensing of drugs.
6. Drugs and medications which may be obtained without a physician's written prescription, except insulin or niacin for cholesterol reduction.
   Note: Certain Vitamins, supplements, and certain over-the-counter items as specified www.healtcare.gov are covered under this plan only when obtained with a physician's prescription, subject to all terms of this Plan that apply to those benefits.
7. Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility.
8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a physician, except prescription contraceptives as specified under "Prescription Drug Services and Supplies That Are Covered".
9. Services or supplies for which you are not charged.
10. Oxygen.
11. Cosmetics and health or beauty aids.
12. Drugs labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications.
13. Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
14. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
15. Drugs used for treating hair loss.
16. Drugs used primarily for the purpose of treating infertility, unless medically necessary for another covered condition.
17. Drugs for the treatment of impotence and/or sexual dysfunction and/or sexual stimulation.
18. Anabolic steroids.
19. Drugs used to enhance athletic performance.
20. Anorexiants and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
21. Drugs obtained outside of the United States unless they are furnished in connection with urgent care or an emergency.
22. Allergy desensitization products or allergy serum.
23. Infusion drugs, except drugs that are self-administered subcutaneously.
24. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a physician for the treatment of phenylketonuria that are obtained from a pharmacy are covered as specified under "Prescription Drug Services and Supplies That Are Covered". Also, vitamins, supplements, and certain over-the-counter items as specified under "Preventive Prescription Drugs and Other Items" are covered under this plan only when obtained with a physician's prescription, subject to all terms of this plan that apply to those benefits.
25. Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Other limitations are shown in the Medical "Exclusions" section of your certificate.

Reimbursement/Filing a Claim

When an Eligible Subscribers purchases their Prescription Drugs or Related Supplies through a retail Participating Pharmacy, they pay any applicable Copayment or Coinsurance shown in the Schedule at the time of purchase. They do not need to file a claim form.

If an Eligible Subscriber purchases their Prescription Drugs or Related Supplies through a non-Participating Pharmacy, they pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

VII. Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Charges for preventive care, injuries or sickness incurred in your Home Country.
5. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with Urgent Care or an Emergency.
6. For or in connection with an Injury or Sickness which is due to participation in a riot, civil commotion or police action.
7. For claim payments that are illegal under applicable law.
8. Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
9. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
10. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations
11. For or in connection with experimental, investigational or unproven services.
    Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.
12. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
13. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty for cosmetic reasons; Redundant skin surgery; Removal of skin tags for cosmetic reasons; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
14. Services and supplies in connection with transgender services, except as specifically stated in the “Transgender Services” provision under the section COVERED EXPENSES BENEFIT DESCRIPTION.
15. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of COVERED EXPENSES BENEFIT DESCRIPTION. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
16. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
17. Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
18. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
19. Infertility, Assisted Reproduction And Sterilization Reversal
    a. Treatment of infertility, including procedures, supplies and drugs;
    b. Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof;

    Please Note: This exclusion does not apply to the diagnosis of infertility or the surgical correction or a condition causing infertility. This would be treated the same as any other medical condition.
20. Reversal of male or female voluntary sterilization procedures.
21. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

22. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
23. Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
24. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
25. Family and marital counseling except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of an insured Subscriber.
26. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
27. Private duty nursing except as provided under the Home Health Services provision.
28. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
29. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
30. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
31. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
32. Vision Treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
33. Vision Exams, Lenses and Hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
34. All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
35. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
36. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
37. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
38. Dental services or supplies except as specifically stated.
39. Orthodontia services, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers.
40. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
41. Blood administration for the purpose of general improvement in physical condition.
42. Cosmetics, dietary supplements and health and beauty aids.
43. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
44. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
45. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
46. Expenses incurred for treatment of sport-related accidental injury resulting from professional sports or participating in any practice or conditioning program for such sport, contest or completion.
47. Consultations provided using telephone, facsimile machine, or electronic mail.

General Limitations

No payment will be made for expenses incurred for an Eligible Subscriber:

1. For charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
2. To the extent that an Eligible Subscriber is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
3. To the extent that payment is unlawful where the person resides when the expenses are incurred.
4. For charges which would not have been made if the person had no insurance.
5. To the extent that they are more than Maximum Reimbursable Charges.
6. To the extent of the exclusions imposed by any certification requirement shown in this plan.
7. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
8. Charges made by any covered provider who is a member of your family or your Dependent's Family.

VIII. General Provisions

Coordination of Benefits

This section applies if the Eligible Subscriber is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan
The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan
A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense
A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules
A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination,
- the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan
If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans for a Claim are not more than 100% of the total of all Allowable Expenses.

When the Allowable Expenses incurred for a Covered Person in any Claim are less than the sum of:
a. the benefits that would be payable under This Plan without applying the Coordination of Benefits provision; and
b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions benefit;

the benefits described in a. of this section will be reduced. The sum of these reduced benefits plus all be benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

Recovery of Excess Benefits
If 4 Ever Life pays charges for benefits that should have been paid by the Primary Plan, or if 4 Ever Life pays charges in excess of those for which we are obligated to provide under the Policy, 4 Ever Life will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

4 Ever Life will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information
4 Ever Life, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligible Insured Participants
Insured Persons eligible for Medicare receive the full benefits of this Plan, except for those Insured Persons listed below:

1. Insured Persons who are receiving treatment for end-stage renal disease following the first 30 months such Insured Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Insured Persons who are entitled to Medicare benefits as disabled persons, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more employees (subject to COBRA legislation).
3. Insured Persons who are entitled to Medicare for any other reason, unless the Insured Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, the Insurer will determine the Insurer's payment and then subtract the amount of benefits available from Medicare. The Insurer will pay the amount that remains after subtracting Medicare's payment. Please note, the Insurer will not pay any benefit when Medicare's payment is equal to or more than the amount which we would have paid in the absence of Medicare.

For example: Assume exception 1, 2 or 3 applies to the Insured Person, and he/she is billed for $100 of Covered Expense. And assume in the absence of Medicare, the Insurer would have paid $80. If Medicare pays $50, the Insurer would subtract that amount from the $80 and pay $30. However, if in this example, Medicare's payment is $80 or more, the Insurer will not pay a benefit.

Third Party Liability

This plan does not cover:

- Expenses incurred by an Eligible Subscriber (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement
If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan
By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Other Provisions

Alternate Cost Containment Provision
If it will result in less expensive treatment, the Insurer may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by the Insurer, the Insured Person, and the Insured Person's Physician, Provider, or other healthcare practitioner. The Insurer's offering an alternate treatment plan in a particular case in no way commits the Insurer to do so in another case, nor does it prevent the Insurer from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Insured Person.

Right of Recovery
We have the right to recover amounts we paid that exceed the amount for which we're liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that Subscriber's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if the contract for this plan is rescinded as described in "Intentionally False or Misleading Statements," we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Plan Administrator
In no event will the Insurer be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than the Insurer, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Eligible Subscriber's agent.

Timely Filing of Claims
You should submit all claims within 180 days of the start of service or within 30 days after the service is completed. We must receive claims:
- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For Subscribers who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

Waiver of Rights
Failure by the Insurer to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Payment of Benefits – To Whom Payable
Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of the Insurer's contracts with providers, all claims from contracted providers should be assigned.

The Insurer may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of the Insurer is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, the Insurer may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, the Insurer may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release the Insurer from all liability to the extent of any payment made.

Recovery of Overpayment
When an overpayment has been made by the Insurer, the Insurer will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

IX. When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you", "your" or "Subscriber" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services
We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please write to us at the following address:

Worldwide Insurance Services, LLC
Attn: Appeals Department
933 First Avenue
King of Prussia, Pennsylvania 19406

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Benefit Determinations

Pre-service Requests for Benefits
Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you file a pre-service request for Benefits improperly, we will notify you how to correct it within five days after your request was received. When we have all needed information, you will receive a written notice from us within 15 days of receipt of the request if the claim is denied.

Urgent Requests for Benefits that Require Immediate Attention
Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:
- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims
If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Post-service Claims
Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. You will receive a written notice from us within 30 days of receipt of the claim if the claim is denied, or we request needed information that was not provided with the claim.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Questions or Concerns about Benefit Determinations
If you have a question or concern about a benefit determination, you may informally contact our *Member Services* department before requesting a formal appeal. If the *Member Services* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Member Services* representative. If you first informally contact our *Member Services* department and later wish to request a formal appeal in writing, you should again contact *Member Services* and request an appeal. If you request a formal appeal, a *Member Services* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Member Services* department immediately.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

4 Ever Life has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within fifteen calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify an additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. 4 Ever Life's or its designee's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal
If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by 4 Ever Life's or its designee's Physician or Dentist reviewer. You may present your situation to the Committee by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. 4 Ever Life's or its designee's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure
If you are not fully satisfied with the decision of 4 Ever Life's or its designee's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by 4 Ever Life or Worldwide Insurance Services, LLC or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. 4 Ever Life will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by 4 Ever Life. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of 4 Ever Life's or its designee's level-two appeal review denial. 4 Ever Life will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by 4 Ever Life's or its designee's Physician reviewer, the review shall be completed within 3 days.

The Independent Review Program is a voluntary program arranged by 4 Ever Life.

Appeal to the State of Delaware
You have the right to appeal a claim denial for medical reasons or to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (302) 674-7310. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. You may also wish to submit a complaint by sending an email to the Delaware Insurance Department at consumer@deins.state.de.us, or by using the complaint form, found at http://www.delawareinsurance.gov/complaint/complaintform. You also can pdf and fax the complaint to (302) 739-6278.

All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information
Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against the Insurer until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Notice of an Appeal or a Grievance
The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

X. Glossary

Administrator
Means Worldwide Insurance Services, LLC

Bed and Board
The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Certification
The term Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Charges
The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with the Insurer for a different amount.

Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Dental Emergency
A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

Dentally Necessary
Those covered services and supplies that a dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, dentist, or other dental care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

Emergency Medical Condition
Emergency medical condition means a medical condition which manifests 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 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services
Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Group
Refers to the entity to which we have issued this Policy.

Home Country
Means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable.

Hospice Care Program
The term Hospice Care Program means:
- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services
The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility
The term Hospice Facility means an institution or part of it which:
- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by the Insurer; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital
The term Hospital means:
- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital
A person will be considered Confined in a Hospital if he is:
- A registered bed patient in a Hospital upon the recommendation of a Physician;
- Receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- Receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:
- For a woman who is under 35 years of age: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury
The term Injury means an accidental bodily injury.

Insurer
Means 4 Ever Life Insurance Company.

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the provider's normal charge for a similar service or supply; or
- a Policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurer or its designee.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by the Insurer. Additional information about how the Insurer determines the Maximum Reimbursable Charge is available upon request.

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity
Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:
- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Morbid Obesity
This means:
- Your **body mass index** (BMI) exceeds 40; or
- Your BMI exceeds 35 and you have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Necessary Services and Supplies
The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement. The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Ophthalmologist
The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Optician
The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

Optometrist
The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

Other Health Care Facility/Other Health Professional
A person who is in a provider category licensed to practice health care related services consistent with the laws in jurisdiction in which the services are performed. Such persons are considered health care providers only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below.

Covered licensed or certified categories of providers, will include the following, provided that the services they furnish are consistent with state law, and the conditions of coverage described elsewhere in this plan are met:

- Acupuncturists (L.Ac.), also called East Asian Medicine Practitioners (E.A.M.P.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they're licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

Note: Outside of the United States, a Provider is a medical professional service provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Participating Pharmacy
The term Participating Pharmacy means a retail Pharmacy with which the Insurer or its designee has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which the Insurer or its designee has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Participating Provider
The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the Insurer or its designee to provide covered services with regard to a particular plan under which the participant is covered.

Pharmacy
The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.)

Note: Outside of the United States, a Physician is a medical professional service provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Plan (also called “This Plan” or "The Plan")
The benefits, terms, and limitations set forth in the Contract between us and the Group, including any endorsements and riders made part of the Contract. This plan is subject to the terms and conditions of the Policy we have issued to the Group.

Policy
The Group Policy we have issued to the Group.

Prescription Drug
Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the Pharmacy & Therapeutics (P&T) Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order
Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment
The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician
Is a Physician who supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician.

Psychologist
The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Recognized Student Health Center
Means a health facility of an educational institution that provides basic health services for students for a minimum of 20 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider and is approved as a Recognized Student Health Center by the Administrator.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization
The term Review Organization refers to an affiliate of the Insurer or another entity to which the Insurer has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Insurance
The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist
A Physician who practices in any generally accepted medical or surgical sub-specialty. Examples include Ob/Gyns, surgeons, cardiologists, urologists, dermatologists.

Stabilize
Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Subscriber (also called "You" and "Your")
A person covered under this plan as an Eligible Participant.

Terminal Illness
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Telehealth
Telehealth means the mode of delivering health care or other health service via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health.

Urgent Care
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Insurer, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Vision Provider
The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

We, Us and Our
Means 4 Ever Life Insurance Company.

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
Worldwide Insurance Services, LLC
100 Matsonford Road, Building One, Suite 100
Radnor, Pennsylvania 19087

Endorsement to Certificate

State of California

By attachment of this Endorsement, it is understood and agreed that the insurance under the Certificate is amended, with respect to covered Persons residing in the state of California, as follows:

1. II. Eligibility, Effective Dates and Coverage Termination Dates is amended by the addition of the following addition as described below:

   Under **Eligibility for Dependent Insurance**, the following class of dependents of insured students may enroll voluntarily in the plan:

   An Eligible Dependent may be the Eligible Subscriber's:
   1. Legally married spouse of the same or opposite sex;
   2. Domestic Partner;
   3. Unmarried dependent children under the age of 26. The term "Children" includes an Eligible Subscriber's biological children, stepchildren and adopted children from the date of placement;
   4. own or spouse's unmarried child, of any age, enrolled prior to age 26, who is incapable of self-support due to continuing mental or physical disability and who is chiefly dependent on the Eligible Subscriber spouse. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 26th birthday and annually thereafter.

2. X. Glossary, the definition of **Dependen**t is hereby amended to include the following:

   Domestic Partner
   A Domestic Partner is defined as the individual designated as an Eligible Subscriber's Domestic Partner under one of the following methods: (i) registration of the partnership with the State of California; (ii) establishment of a same-sex legal union, other than marriage, formed in another jurisdiction that is substantially equivalent to a State of California-registered domestic partnership; or (iii) filing of a Declaration of Domestic Partnership form with the University. An Eligible Subscriber's opposite-sex Domestic Partner will be eligible for coverage only if one or both partners are age 62 or older and eligible for Social Security benefits based on age.

3. IV. Covered Expenses Benefit Description is amended by the addition of the following benefits described under their respective headings**:**

   Maternity Care/Obstetrical Services
   Benefits are provided for participation in the Expanded Alpha Feto Protein (AFP) prenatal testing Program.

   Prenatal Diagnosis of Genetic Disorders
   Benefits are paid for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of High-risk Pregnancy. High-risk pregnancy means a pregnancy in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth and must be classified as having one of the following risk factors:
   - Moderate to severe preeclampsia (toxemia);
   - Chronic hypertension;
   - Moderate to severe renal disease;
   - Severe heart disease (class II-IV);
   - Insulin-dependent diabetes;
   - Uterine malformation;
   - Incompetent cervix;
   - Polyhydramnios or oligohydramnios; or
   - Placenta previa.

   Under **Covered Expenses,** Charge made for the following preventive care services, is to include:
   - Benefits for diagnosis, treatment and management of osteoporosis including bone mass measurement technologies as deemed Medically Necessary.
   - Benefits are also provided for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

– **Contraception.** This plan provides coverage for all of the following services and contraceptive methods for women with NO cost sharing:
  - All FDA-approved contraceptive drugs, devises and products available over the counts, as prescribed by the enrollee's provider;
  - Voluntary sterilization procedures;
  - Patient education and counseling on contraception
  - Follow-up services related to the drugs, devices, products and procedures covered under this benefit, including, but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

Prostheses/prosthetic Appliances and Devices
Benefits will include prosthetic devices to restore a method of speaking for a Covered Person incidental to a laryngectomy. Coverage will be subject to the deductible and coinsurance conditions applied to the laryngectomy and all other terms and conditions applicable to other benefits.

As used in this Endorsement "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to a physician's order. "Prosthetic devices" does not include electronic voice producing machines.

4. VI. Prescription Drug Benefits is amended by the addition of the following benefits

Hormone Replacement Therapy: coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

Oral Anti-Cancer Prescription Drugs. For orally administered anti-cancer medications, the Deductible, if any, will not apply and the Copayment will not exceed the lesser of the applicable Copayment shown in the Summary of Benefits or $200 for a 30-day supply for medications obtained at a retail pharmacy.

Under **Prescription Drug Conditions of Service** the following language is added:

Approved for use by the Food and Drug Administration. Notwithstanding, benefits are provided for drugs prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:
a. The American Medical Association Drug Evaluations;
b. The American Hospital Formulary Service Drug Information;
c. The United States Pharmacopoeia Drug Information; or
d. It is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

5. IX. When you have a Complaint or an Appeal, is amended to include:

CALIFORNIA
CONSUMER COMPLAINT DISCLOSURE

California Department of Insurance
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013

Telephone Numbers:
800-927-HELP-4357 (Calling from within CA)
213-897-8921 (Outside California)
800-482-4833 (TDD - Telecommunication Devices for the Deaf)
Website: http://www.insurance.ca.gov

If You need assistance with the translation of this notice in a language other than English, please contact us at (800) 621-9215.

To contact 4 Ever Life Insurance Company You may:

- Call Us by dialing Our toll free number at: (800) 621-9215
- Write Us at the following address:

4 Ever Life Insurance Company
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181-4712

The Department of Insurance should be contacted ONLY after discussions with 4 Ever Life Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

THIS ENDORSEMENT IS SUBJECT TO ALL PROVISIONS OF THE CERTFICIATE NOT INCONSISTENT HEREWITH.

PRESIDENT

SECRETARY