UnitedHealthcare Choice

Certificate of Coverage, Riders, Amendments and Notices
for
the Plan #001M
of

City of Milwaukee

Group Number: 712481
Effective Date: January 1, 2010

Offered and Underwritten by
United HealthCare Insurance Company

Riders, Amendments, and Notices
begin immediately following the last page of the Certificate of Coverage

United HealthCare Insurance Company

UnitedHealthcare Choice

Certificate of Coverage

Eligible Expenses for Covered Health Services are determined solely in accordance with our reimbursement policy guidelines, as defined in Section 10 of this certificate. We develop our own reimbursement policy guidelines, in our discretion based on data resources of competitive fees in that geographic area and the Eligible Expenses may be less than the billed charge.

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Certificate of Coverage

United HealthCare Insurance Company

UnitedHealthcare Choice

Certificate is Part of Group Policy

This Certificate of Coverage is part of the group Policy that is a legal document between United HealthCare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this Certificate the Policy includes:

- The Enrolling Group's application.
- Any Amendments and Riders.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages.

To continue reading, go to right column on this page.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

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

This Certificate describes Benefits in effect as of January 1, 2010 for City of Milwaukee.

On its effective date this Certificate replaces and overrules any Certificate that we may have previously issued to you. This Certificate will in turn be overruled by any Certificate we issue to you in the future.

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

We are delivering the Policy in the State of Wisconsin. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Wisconsin are the laws that govern the Policy.

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Introduction to Your Certificate

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

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this Certificate by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions.) You should also carefully read (Section 9: General Legal Provisions) to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

Please be aware that your Physician does not have a copy of your Certificate of Coverage, and is not responsible for knowing or communicating your Benefits.

To continue reading, go to right column on this page.

Information about Defined Terms

Because this Certificate is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your Certificate.

When we use the words "we," "us," and "our" in this document, we are referring to United HealthCare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Required Premiums

The Policy may require the Subscriber to contribute to the required Premiums. You can contact your Enrolling Group for information about any part of the Premium cost you are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Service listed on your ID card. It will be our pleasure to assist you.

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Section 1: What's Covered—Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Policy Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered—Exclusions).
- Covered Health Services that require you or your provider to notify us before you receive them. In general, Network providers are responsible for notifying us before they provide certain health services to you.

Accessing Benefits

With UnitedHealthcare Choice, you must see a Network Physician to obtain Benefits. For details, see (Section 3: Obtaining Benefits).

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

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

- Covered Health Services are received while the group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For a complete definition of Eligible Expenses that describes how we determine payment, see (Section 10: Glossary of Defined Terms). You are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

To continue reading, go to left column on next page.

Notification Requirements

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying us.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits.	No Annual Deductible.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments.	No Out-of-Pocket Maximum.
Maximum Policy Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see (Section 10: Glossary of Defined Terms).	$1,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	*Ground Transportation:* No Copayment up to $300. 20% for charges in excess of $300. *Air Transportation:* No Copayment up to $1,000. 20% for charges in excess of $1,000.
2. Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services Hospital or ambulatory surgery center charges provided in conjunction with dental care, including anesthetics provided, if any of the following applies: • The Covered Person is a child under the age of 5. • The Covered Person has a chronic disability. • The Covered Person has a medical condition requiring hospitalization or general anesthesia for dental care.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
3. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
teeth that are injured as a result of such activities. Please remember that you must notify us as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.)	
4. Diabetes Treatment Diabetes equipment and supplies, expenses incurred by the installation and use of an insulin infusion pump and diabetes self-management education programs. Benefits are limited to one pump per calendar year.	No Copayment
5. Durable Medical Equipment, Prosthetic and Orthotics Benefits are provided for Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.	20% up to $500. 0% in excess of $500

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years. We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor we identify.	
• Benefits are provided for external prosthetic devices that replace a limb or an external body part, limited to:	

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Benefits are provided for the following:

- Orthotics which are custom made or custom fit made of rigid or semi-rigid material.
- Initial pair of eyeglasses or contacts needed due to cataract surgery or due to an accident if the eyeglasses or contracts were not needed prior to such accident.

Any combination of Benefits for DME, Prosthetic and Orthotics is limited to $500 per calendar year.

Once this Benefit limit is reached, no additional Benefits are available except for prosthetic items required by the Women's

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Health and Cancer Rights Act of 1998.	
6. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	$25 per visit
7. Enteral Formulas Enteral formulas for use at home by a Covered Person that are prescribed or ordered by a Physician and are for treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).	No Copayment
8. Eye Examinations Eye examinations received from a health care provider in the provider's office. Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.	No Copayment
9. Home Health Care Services received from a Home Health Agency that are both of the	No Copayment

following:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

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

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

- It must be delivered or supervised by licensed technical or professional medical personnel 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.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

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

Benefits are limited to 50 visits per calendar year. One visit equals

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
four hours of skilled care services.	
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card. Benefits are limited to 180 days during the entire period of time you are covered under the Policy.	No Copayment
11. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	No Copayment
12. Injections received in a Physician's Office	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	
13. Kidney Disease Treatment Inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-related services. Benefits are limited to $30,000 per calendar year.	No Copayment
14. Maternity Services Benefits for Pregnancy will be paid, for all Covered Persons under the Policy, at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services. No Copayment applies to Physician office visits for prenatal care after the first visit.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

15. Medical Supplies

No Copayment

Benefits are provided for the following medical supplies when prescribed by your Physician subject to a 30 day supply:

- Surgical dressings
- Catheters
- Colostomy bags
- Rings
- Belts
- Floatation pads

16. Mental Health and Substance Abuse Services - Outpatient

No Copayment

Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.

- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Coverage will also be provided for the Mental Health and Substance Abuse clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Mental Health/Substance Abuse Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Abuse Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Mental Health/Substance Abuse Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a Full-time Student.

Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits for Mental Health Services and/or Substance Abuse Services are limited to 20 visits per calendar year or $2,000 whichever is greater. **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.	
17. Mental Health and Substance Abuse Services - Inpatient Mental Health Services and Substance Abuse Services received on an inpatient basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will arrange for the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health/Substance Abuse	No Copayment

provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient Mental Health Services and Substance Abuse Services.

Benefits for Mental Health Services and/or Substance Abuse Services are limited to 30 days per calendar year or $7,000 whichever is greater.

Authorization Required

Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card.

Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

18. Mental Health and Substance Abuse Services - Transitional

No Copayment

Mental Health Services and Substance Abuse Services received on a transitional care basis including:

- Services for children and adults in day treatment programs.
- Services for persons with chronic Mental Illness through support programs.
- Residential treatment programs for alcoholism and other drug

dependent Covered Persons.

- Chemical dependency services for alcoholism and other drug problems provided in day treatment programs.
- Intensive outpatient programs for the treatment of psychoactive substance abuse disorders provided in accordance with the patient placement criteria of the American Society of Addictive Medicine.

The Wisconsin Department of Health and Social Services must certify day treatment programs, community support programs and residential treatment programs.

Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding the Benefits for transitional Mental Health Services and Substance Abuse Services.

Benefits for Mental Health Services and/or Substance Abuse Services are limited to 20 days per calendar year or $3,000 whichever is greater.

Authorization Required

Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.	
19. Oral Surgery Benefits are provided for oral surgery as described below: • Excision of partially or completely impacted teeth. • Excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth. • Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth • Reduction of fractures and dislocations of the jaw. • External incision and drainage of cellulitis. • Frenectomy (the cutting of the tissue in the midline of the tongue and incision of any midline fold of tissue between jaws and lips and between the lower jaw and tongue. • Apicoectomy (the excision of apex of the tooth root). • Excision of exostoses of the jaws and hard palate. • Treatment of fractures of facial bones. • Gingivectomy (excision of loose gum tissue to eliminate infection) and related x-rays. • Removal of retained (residual) root; • Gingival curettage under general anesthesia.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Alveolectomy (the leveling of structures supporting teeth for the purpose of dentures). We do not cover alveolectomy when it is performed in connection with the extraction of natural teeth. • Periodontal surgery (the surgical treatment of periodontal disease of the gums and supportive tissue of the teeth). • Root amputation. • Vesibuloplasty (the surgical modification of the gingival mucous membrane). •	
20. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray, including blood lead tests for children under 6 years of age. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical*	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
and Medical Services below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	
21. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.) • Immunizations, including but not limited to: — Diphtheria — Pertussis — Tetanus — Polio — Measles — Mumps — Rubella	No Copayment No Copayment applies to immunizations for children from birth to age 6.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
— Hemophilus influenza B — Hepatitis B — Varicella • Pap tests, pelvic examinations or related Covered Health Services performed by a licensed nurse practitioner.	
22. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	No Copayment
23. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.

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

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

24. Rehabilitation Services - Outpatient Therapy

No Copayment

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Benefits are limited as follows: • 50 visits of physical therapy per calendar year. • 50 visits of occupational therapy per calendar year. • 50 visits of speech therapy per calendar year.	
25. Routine Foot Care Benefits are provided for routine foot care. Routine foot care includes cutting or removal of corns and calluses, trimming, cutting, clipping or debriding of nails. Benefits are provided only for Covered Persons who have a systemic condition, such as metabolic, neuralgic, or peripheral vascular disease, or systemic condition with severe circulatory problems that require foot care by a professional, and the condition requires that this care be received by a skilled professional.	No Copayment
26. Skilled Nursing Facility/Inpatient	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility and Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). For Skilled Nursing Facility Services, Benefits are limited to 120 days per Inpatient Stay. For Inpatient Rehabilitation Facility Services, Benefits are limited to 120 days per calendar year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	No Copayment
27. Temporomandibular Joint Disorders Diagnostic procedures and surgical or nonsurgical treatment (including prescribed intraoral splint therapy devices,) for the correction of temporomandibular joint (TMJ) disorders, if all of the following apply: • The disorder is caused by congenital, developmental or acquired deformity, Sickness or Injury. • The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.	20%

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. Benefits are not available for cosmetic or elective orthodontic care, periodontic care or general dental care. Benefits for diagnostic procedures and nonsurgical treatment are limited to $1,250 per calendar year.	
28. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Muscular/Skeletal transplants. • Pancreas transplants. • Small bowel transplants. Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.	
29. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section. To ensure prompt and accurate payment of your claim, notify us within two business days after you receive care at an Urgent Care Center outside the Service Area.	No Copayment

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Policy.

How We Use Headings in this Section

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

We Do not Pay Benefits for Exclusions

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

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

To continue reading, go to right column on this page.

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

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - — Air conditioners.
   - — Air purifiers and filters.
   - — Batteries and battery chargers.
   - — Dehumidifiers.
   - — Humidifiers.
6. Devices and computers to assist in communication and speech.

To continue reading, go to left column on next page.

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the headings *Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services, Dental Services - Accident only, Oral Surgery* and *Temporomandibular Joint Disorders*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions except as described under the heading *Oral Surgery* in (Section 1: What's Covered--Benefits).
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation.
   - Initiation of immunosuppressives.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.
   - Hospitalizations and anesthesia described in (Section 1: What's Covered--Benefits) under the heading *Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

To continue reading, go to right column on this page.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

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

Note: Determinations of whether a service is considered to be Experimental, Investigational or Unproven are based on clinical studies criteria. These decisions are made by our Medical Director in consultation with a specialty review panel. When we receive a request for an Experimental, Investigational or Unproven service, we will issue a Benefit decision within 5 working days. If we decide there is no coverage for the Experimental, Investigational or Unproven treatment, procedure or device for a Covered Person with a terminal condition or Sickness, we will include the following information in the non-coverage letter:

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

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F. Foot Care

The exclusions listed below do not apply to Benefits which are provided as described under *Routine Foot Care* in (Section 1: What's Covered --Benefits).

1. Routine foot care (including the cutting or removal of corns and calluses).
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   - — Cleaning and soaking the feet.
   - — Applying skin creams in order to maintain skin tone.
   - — Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - — Elastic stockings.
   - — Ace bandages.
   - — Gauze and dressings.
   - — Syringes, except for insulin syringes.

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This exclusion does not apply to Benefits which are provided as described under *Medical Supplies* in (Section 1: What's Covered--Benefits)

3. Orthotic appliances that straighten or re-shape a body part (including some types of braces) except for Benefits which are provided as described under --*Durable Medical Equipment, Prosthetics and Orthotics* in (Section 1: What's Covered—Benefits).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.

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6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

   The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Nutrition

1. Megavitamin and nutrition based therapy. This exclusion does not include nutritional counseling services received in a Physician's Office.

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2. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except for benefits described under *Enteral Formulas* in (Section 1: What's Covered--Benefits).

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or

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child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization
4. Health services and associated expenses for elective abortion, unless the pregnancy would endanger the life of the mother; the pregnancy is a result of rape or incest, or the fetus has been diagnosed with a lethal or otherwise significant abnormality.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

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   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What's Covered--Benefits).

O. Travel

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

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2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids except for Benefits which are provided as described under *Durable Medical Equipment, Prosthetics and Orthotics* in (Section 1: What's Covered--Benefits).
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

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4. Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising before the date your coverage under the Policy ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature beyond the limits described in (Section 1: What's Covered--Benefits) under the heading *Temporomandibular Joint Disorders*.
8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery and jaw alignment except as a treatment of obstructive sleep apnea.
9. Surgical and non-surgical treatment of obesity, including morbid obesity.
10. Growth hormone therapy.
11. Sex transformation operations.
12. Custodial Care.
13. Domiciliary care.
14. Private duty nursing.
15. Respite care.
16. Rest cures.
17. Psychosurgery.
18. Treatment of benign gynecomastia (abnormal breast enlargement in males).
19. Medical and surgical treatment of excessive sweating (hyperhidrosis).

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20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Oral appliances for snoring.
22. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.

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Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the Service Area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

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Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

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

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Service.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider.

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

Continuity of Care

If a provider leaves the network or is unavailable to you, we will cover services, if we represent the provider as a member of the network in the marketing materials that are provided or available at the most recent open enrollment period.

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If you are undergoing a course of treatment with a Network provider who is no longer available, we will provide coverage for the remainder of the course of treatment or 90 days, whichever is shorter. If maternity care is the course of treatment and the Covered Person is in their 2nd or 3rd trimester of pregnancy, we will provide coverage until the completion of postpartum care for the mother and infant.

Coverage will not be provided, if the provider no longer practices in the Service Area or we terminate the provider's contract for misconduct on his/her part.

*Care Coordination*SM

Your Network Physician is required to notify us regarding certain proposed or scheduled health services. When your Network Physician notifies us, we will work together to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify us. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify us, we will provide you the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

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

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services , even if one or more of those Covered Health Services is received from a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

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Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within 48 hours or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.
- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

  Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the properly completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

To continue reading, go to right column on this page.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy.

You should notify us within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

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

Your Benefits under the Policy may also be reduced if you are enrolled in a Medicare+Choice (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

To continue reading, go to left column on next page.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see (Section 10: Glossary of Defined Terms). Eligible Persons must reside within the United States. If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	We and the Enrolling Group determine who is eligible to enroll under the Policy.
Dependent	Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a completed definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy. If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll without our written permission.	We and the Enrolling Group determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified in this Certificate if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	We and the Enrolling Group determine the Open Enrollment Period. Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.
Adding New Dependents	Subscribers may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption.	Coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible. In the case of a newborn infant, Coverage begins from the moment of birth and must

- Marriage.
- Legal guardianship.
- Court or administrative order.

include Congenital Anomalies and birth abnormalities as an Injury or Sickness.

We must receive notification of the event and any required Premium within 60 days after the date of birth.

If you fail to notify us and do not make any required payment beyond the 60 day period, coverage will not continue, unless you make all past due payments with 5 ½% interest, within one year of the child's birth. In this case, Benefits are retroactive to the date of birth.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

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

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - The employer stopped paying the contributions.
  - In the case of COBRA continuation coverage, the coverage ended.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event.

Note: In the case of a newborn, the same situation applies as noted in *Adding New Dependents* above.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

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You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

A. The Subscriber's name and address.
B. The patient's name and age.
C. The number stated on your ID card.
D. The name and address of the provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or

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program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. Benefits will be paid to you unless either of the following is true:

A. The provider notifies us that your signature is on file, assigning benefits directly to that provider.
B. You make a written request at the time you submit your claim.

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Section 6: Questions, Complaints, Grievances

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Policy.

As used in this section:

a. "complaint" means your expression of dissatisfaction with us or any Network provider.

b. "expedited grievance" means a grievance where the standard resolution process may include any of the following:
   1. Serious jeopardy to your life or health or your ability to regain maximum control.
   2. Severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance, in the opinion of a Physician with knowledge of your condition.
   3. A Physician with knowledge of your condition determines that it is an expedited grievance.

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c. "grievance" means any dissatisfaction with our administration, claims practices or provision of services that is expressed in writing, to us by you or on your behalf.

To resolve a question, complaint, or grievance, just follow these steps:

What to Do First

Contact Our Customer Service Department

The telephone number is shown on your ID card.

Customer Service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail.

Please note: If the complaint relates to a claim payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any new information to support your request for claim payment.

A Customer Service representative will return your call and attempt to address your complaint through informal discussion. If you would rather send your concern to us in writing at this point, the Customer Service representative can provide you with the appropriate address to file a grievance.

To continue reading, go to left column on next page.

Grievance Process

Each time we deny a claim or Benefit or initiate disenrollment proceedings, we will notify you of your right to file a grievance.

We will acknowledge a grievance, in writing, within 5 days of its receipt and resolve the grievance within 30 calendar days of its receipt. If we are unable to resolve the grievance within that time, we will extend the time period by an additional 30 calendar days, if you receive notification that the grievance has not been resolved, additional time is needed and the expected date the grievance will be resolved.

You or an authorized representative have the right to appear in person before the grievance committee to present written or oral information. We will notify you, in writing, of the time and place of the meeting at least 7 calendar days before the meeting.

Following a review of your grievance, you will receive a written notification of the committee's decision, along with the titles of the people on the grievance committee.

What to Do if Your Grievance Requires Immediate Action

In situations where the normal duration of the grievance process could have adverse effects on you, a grievance will not need to be submitted in writing. Instead, you or your Physician should contact us as soon as possible. We will resolve the grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we will notify you of our decision by the end of the next business day following receipt of the required information.

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The complaint process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that we do not consider urgent situations.

What to Do if You Disagree with Our Decision

You have the right to take your complaint to The Office of the Commissioner of Insurance, if you are not satisfied with our decision or at any time you are dissatisfied with our administration of your Benefits. The address and telephone number are as follows:

Office of the Commissioner of Insurance

Complaints Department P.O. Box 7873

Madison, WI 53707-7873

You may also call to request a complaint form at (800) 236-8517 (outside of Madison) or 608-266-0103 in Madison or email them at http://badger.state.wi/agencies/oci/emailoci.htm.

Please note that our decision is based only on whether or not Benefits are available under the Policy. We do not determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

External Review

You or your authorized representative may request and obtain an external review of an adverse determination or the exclusion for Experimental, Investigational or Unproven Services.

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The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the external review program.

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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Definitions

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

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2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Policy. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

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

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2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

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4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:
   1. Determine its obligation to pay or provide benefits under its contract;
   2. Determine whether a benefit reserve has been recorded for the Covered Person; and
   3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

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

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

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

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

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Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess

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from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage under federal law (COBRA) and under state law.
- Conversion.

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General Information about When Coverage Ends

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

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

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Group Policy Ends	Your coverage ends on the date the group Policy ends. The Enrolling Group is responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more completed definition of the terms "Eligible Person", "Subscriber", "Dependent" and "Enrolled Dependent."
We Receive Notice to End Coverage	Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.
Subscriber Retires or Is Pensioned	Your coverage ends the last day of the calendar month in which the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to us to end your coverage. This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Policy.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required Copayment.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

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

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

We will ask you to furnish us with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year, after the two-year period immediately following the time the child reaches the limiting age.

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

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Extended Coverage for Total Disability

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

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy was terminated.
- The maximum Benefit is paid.
- The succeeding insurer's group policy provides coverage for the condition(s) causing the Total Disability.

Continuation of Coverage and Conversion

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

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

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

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

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

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

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.

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Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Subscriber; or
C. Divorce or legal separation of the Subscriber; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Subscriber to Medicare benefits; or
F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan

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administrator of these events within the 60 day period, the Enrolling Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Enrolling Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

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

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

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F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Policy ends.

H. The date coverage would otherwise terminate under the Policy as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

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Qualifying Events for Continuation Coverage under State Law

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

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

Notification Requirements and Election Period for Continuation Coverage under State Law

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

Terminating Events for Continuation Coverage under State Law

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

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- The date the Covered Person establishes residence outside of the state.
- 18 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- For a spouse, the date the Subscriber's group coverage ends.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under this Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Policy.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Policy.

Your Relationship with Us

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

- We communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you may receive. The plan pays for certain medical costs, which are more fully described in this Certificate. The plan may **not** pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.
- We do not decide what care you need or will receive. You and your Physician make those decisions.

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

To continue reading, go to right column on this page.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

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

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

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

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).

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- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

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

Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

To continue reading, go to right column on this page.

Notice

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

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or

To continue reading, go to left column on next page.

arranging to provide the Covered Person's health care is less than or more than the payment.

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

Incentives to You

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

Interpretation of Benefits

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

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

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

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

Administrative Services

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

Amendments to the Policy

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

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

To continue reading, go to left column on next page.

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

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

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending us inaccurate information regarding your enrollment for coverage or the termination of your coverage under the Policy) we will not make retroactive adjustments beyond a 60-day time period.

Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proofs that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us

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with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

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

Examination of Covered Persons

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

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Workers' Compensation not Affected

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

Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

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Subrogation and Reimbursement

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

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Policy.

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- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That after you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Policy.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Policy. We may also reduce future Benefits under any other group benefits plan that we administer for the Enrolling Group. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim). If you want to bring a legal action against us you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us.

You cannot bring any legal action against us for any other reason unless you first complete all the steps in the complaint process described in (Section 6: Questions, Complaints, Appeals). After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your complaint or you lose any rights to bring such an action against us.

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Entire Policy

The Policy issued to the Enrolling Group, including this Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitutes the entire Policy.

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Certificate.
- Is not intended to describe Benefits.

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

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

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

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

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

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

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

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

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Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

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

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

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

- A Dependent includes any unmarried dependent child under 19 years of age.
- A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - — The child must not be regularly employed on a full-time basis.
  - — The child must be a Full-time Student.
  - — The child must be primarily dependent upon the Subscriber for support and maintenance.

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

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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

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

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

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Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - — They have a single dedicated relationship of at least six months duration.
  - — They have joint ownership of a residence.
  - — They have at least two of the following:
    - ♦ A joint ownership of an automobile.
    - ♦ A joint checking, bank or investment account.
    - ♦ A joint credit account.
    - ♦ A lease for a residence identifying both partners as tenants.
    - ♦ A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

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

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

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are the fee(s) that we negotiate with the non-Network provider.

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, including severe pain which would lead a prudent layperson with an average knowledge of health

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and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following.

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

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

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

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

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

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

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar year during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

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Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

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

Initial Enrollment Period - the initial period of time, as we agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

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

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

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

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in Section 4.
- Within 31 days of the date a new Eligible Person first becomes eligible.

Maximum Policy Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. The Maximum Policy Benefit includes any amount that we have paid for Benefits under a former Policy issued to the Enrolling Group that is replaced by the current Policy, as well as any amount that we may pay under a later Policy that replaces the Enrolling Group's current Policy. When the Maximum Policy Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

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

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

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Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with us or with our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

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

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Enrolling Group will agree upon the period of time that is the Open Enrollment Period.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any dentist, chiropractor, optometrist, nurse practitioner or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group, that includes all of the following:

- The group Policy.
- This Certificate of Coverage.

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- The Enrolling Group's application.
- Amendments.
- Riders.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

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

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

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

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

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

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

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

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

Transitional Care - Mental Health Services and Substance Abuse Services provided in a less restrictive manner than inpatient hospital services but more intensive than outpatient services.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

-End of Certificate-

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Riders, Amendments, Notices

2002 Amendment to the Certificate of Coverage

Ostomy Supplies Rider

Ambulance, Emergency Services, Diabetes Treatment, Compression Stockings, Durable Medical Equipment and Coordination of Benefits Amendment

Women's Health and Cancer Rights Act of 1998

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Claims and Appeal Notice

HIPAA Notice

COBRA Notice

Notice of Privacy Practices

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

Financial Information Privacy Notice

2002 Amendment to the Certificate of Coverage

The Certificate of Coverage is modified as described in this Amendment.

Section 1: What's Covered--Benefits

Durable Medical Equipment described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Durable Medical Equipment, Prosthetic and Orthotics Benefits are provided for Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes.	20% up to $500. 0% in excess of $500

- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every

three calendar years.

We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor we identify.

Benefits are provided for external prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Benefits are provided for the following:

- Orthotics which are custom made or custom fit made of rigid or semi-rigid material.
- Initial pair of eyeglasses or contacts needed due to cataract

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
surgery or due to an accident if the eyeglasses or contracts were not needed prior to such accident.	
Any combination of Benefits for DME, Prosthetic and Orthotics is limited to $500 per calendar year.	
Once this Benefit limit is reached, no additional Benefits are available except for prosthetic items required by the Women's Health and Cancer Rights Act of 1998.	

Outpatient Surgery, Diagnostic and Therapeutic Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Outpatient Surgery, Diagnostic and Therapeutic Services	
Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray, including blood lead tests for children under 6 years of age. • Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.	***For lab and radiology/ X-ray:*** No Copayment ***For mammography testing:*** No Copayment
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	No Copayment

Physician's Office Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Physician's Office Services Covered Health Services received in a Physician's office including: • Diagnosis and treatment of a Sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.) • Immunizations. • Pap tests, pelvic examinations or related Covered Health Services performed by a licensed nurse practitioner.	No Copayment No Copayment applies to immunizations for children from birth to age 6.

Professional Fees for Surgical and Medical Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	No Copayment

Section 2: What's Not Covered--Exclusions

Section 2 is modified by replacing exclusion #3 under Mental Health/Substance Abuse with the following exclusion:

Mental Health/Substance Abuse

3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

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Section 3: Obtaining Benefits

Designated Facilities and Other Providers in (Section 3: Obtaining Benefits) is replaced with the following:

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

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

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

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Emergency Health Services in (Section 3: Obtaining Benefits) is replaced with the following:

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within 48 hours or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.

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Section 9: General Legal Provisions

Subrogation and Reimbursement is replaced with the following:

Subrogation and Reimbursement

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

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate of Coverage, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

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- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

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- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That after you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.

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- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

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Section 10: Glossary of Defined Terms

The definition of Alternate Facility is replaced with the following:

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

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

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

The definition of Designated Facility is replaced with the following:

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

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The definition of Eligible Expenses is replaced with the following:

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

The definition of Network is replaced with the following:

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

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the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

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Ostomy Supplies Rider

We provide Benefits for the ostomy supplies as described in this Rider to the Policy.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive remover, deodorant, pouch covers, or other items not listed above.	0%

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

Ambulance, Emergency Services, Diabetes Treatment, Compression Stockings, Durable Medical Equipment and Coordination of Benefits Amendment

As described in this Amendment, the Policy is modified coverage for Ambulance, Compression Stockings, Diabetes Treatment and the Coordination of Benefits section was also updated.

Section 1: What's Covered--Benefits

Ambulance Services - Emergency only, Diabetes Treatment and Medical Supplies in the Certificate of Coverage, (Section 1: What's Covered--Benefits) are replaced with the following:

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	Ground Transportation: No Copayment up to $300. 20% for charges in excess of $300.

	Air Transportation: No Copayment up to $1,000. 20% for charges in excess of $1,000.
Diabetes Treatment Diabetes equipment and supplies, including expenses incurred by the installation and use of an insulin infusion pump, insulin or any other prescription medication and diabetic self-management education programs. Benefits are limited to one pump per calendar year. Covered Persons may participate in the Enrolling Group's disease management program for diabetics. The Enrolling Group may provide financial incentives for participating in this program. For details on this program you may contact the Enrolling Group's Employee Relations department.	No Copayment.
Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	$25 per visit Copayment is waived when admitted to hospital as an Inpatient, or if your Physician has referred to you to the Emergency room for

	treatment.
Medical Supplies Benefits are provided for the following medical supplies when prescribed by your Physician subject to a 30 day supply: • Surgical dressings • Catheters • Colostomy bags • Rings • Belts • Floatation pads • Compression Stockings	0%

Section 2: What's Not Covered-- Exclusions

The exclusion for Medical Supplies and Appliances in the Certificate under (Section 2: What's Not Covered--Exclusions) is replaced with the following:

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   — Ace bandages.

   — Gauze and dressings.

   — Syringes, except for insulin syringes.

   This exclusion does not apply to Benefits which are provided as described under *Medical Supplies* in (Section 1: What's Covered--Benefits).
3. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

Section 7: Coordination of Benefits

The provision in the Certificate under (Section 7: Coordination of Benefits), is replaced with the following:

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

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

Definitions

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

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

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1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

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

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

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

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C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

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

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

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

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

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

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

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

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

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

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

(a) The Plan covering the Custodial Parent.

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

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

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

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

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

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Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

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

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

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

   — The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

   — The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

   — The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

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   — The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

   — The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made"

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includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

When Medicare is Secondary

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

UNITED HEALTHCARE INSURANCE COMPANY

Allen J. Sorbo, President

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Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

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Claims and Appeal Notice

This Notice is provided to you as a result of changes in federal law regarding our responsibilities for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

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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.

If you have prescription drug benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

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 have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the

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information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. 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 appeal procedures.

If you have prescription drug benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

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.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

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

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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.

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Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our customer service department before requesting a formal appeal. If the customer service 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 customer service representative. If you first informally contact our customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service 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 customer service department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

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- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of **pre-service requests for Benefits** as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

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- For appeals of **post-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

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HIPAA Notice

Changes Required By Final HIPAA Regulations

Changes required by the final HIPAA Portability Regulations are effective July 1, 2005. Those changes include clarification of the requirements for a Special Enrollment Period and Continuous Creditable Coverage as described below.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

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

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

- Birth.
- Legal adoption.

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- Placement for adoption.
- Marriage.

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

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or any applicable Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - — In the case of COBRA continuation coverage, the coverage ended.
  - — The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - — The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - — An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Continuous Creditable Coverage

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Continuous Creditable Coverage is defined as health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Maximum Policy Benefit

The terms of your Certificate of Coverage may define and establish terms relating to a Maximum Policy Benefit. This maximum policy benefit may impose a preexisting condition limitation under the updated HIPAA Portability regulations.

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COBRA Notice

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified

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Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct.
B. Reduction in the Subscriber's hours of employment.

With respect to a Subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than the Subscriber's gross misconduct.
B. Reduction in the Subscriber's hours of employment.
C. Death of the Subscriber.
D. Divorce or legal separation of the Subscriber.
E. Loss of eligibility by an Enrolled Dependent who is a child.
F. Entitlement of the Subscriber to Medicare benefits.
G. The Enrolling Group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

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Notification Requirements for Qualifying Event

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator within 60 days of the latest of the date of the following events:

- The Subscriber's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Subscriber or other Qualified Beneficiary must also notify the Enrolling Group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Subscriber or other Qualified Beneficiary fails to notify the Enrolling Group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under federal law, the Subscriber must notify the Enrolling Group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the Enrolling Group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

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None of the above notice requirements will be enforced if the Subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Enrolling Group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Enrolling Group for additional information. You must contact the Enrolling Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

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

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   — Notice of such disability must be provided within the latest of 60 days after:
     - the determination of the disability; or
     - the date of the qualifying event; or
     - the date the Qualified Beneficiary would lose coverage under the Policy; and
     - in no event later than the end of the first eighteen months.

   — The Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven months.

   — If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Subscriber was entitled to Medicare prior to the qualifying event:

   — Eighteen months from the date of the Subscriber's Medicare entitlement; or

   — Thirty-six months from the date of the Subscriber's Medicare entitlement, if a second qualifying event (that was due to either the Subscriber's termination of employment or the Subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Subscriber became entitled to Medicare subsequent to the qualifying event:

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— Thirty-six months from the date of the Subscriber's termination from employment or work hours being reduced (first qualifying event) if:

- The Subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Subscriber's death.

H. The date the entire Policy ends.

I. The date coverage would otherwise terminate under the Policy as described in the Certificate of Coverage (Section 8: When Coverage Ends) under the heading *Events Ending Your Coverage*.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website, www.myuhc.com.

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*ACN Group of California, Inc.; All Savers Insurance Company; American Medical Security Life Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; IBA Health and Life Assurance Company; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Behavioral Health, Inc.; PacifiCare Behavioral Health of California, Inc.; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Behavioral Health of New Jersey, Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Insurance Company, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Plan of the River Valley, Inc.; and U.S. Behavioral Health Plan, California.

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How We Use or Disclose Information

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

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

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

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health.
- ***To Provide Information on Health Related Programs or Products*** such as alternative medical treatments and programs or about health related products and services.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

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We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care.*** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers Compensation*** including disclosures required by state workers compensation laws of job-related injuries.

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- ***For Research Purposes*** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- ***To Provide Information Regarding Decedents***. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- ***For Organ Procurement Purposes***. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a Summary of State Laws on Use and Disclosure of Certain Types of Medical Information.

What Are Your Rights

The following are your rights with respect to your health information.

- ***You have the right to ask to restrict*** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. ***Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.***
- ***You have the right to ask to receive confidential communications*** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).

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- ***You have the right to see and obtain a copy*** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- ***You have the right to ask to amend*** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- ***You have the right to receive an accounting*** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- ***You have the right to a paper copy of this notice***. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.myuhc.com.

Exercising Your Rights

- ***Contacting your Health Plan***. If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.

To continue reading, go to right column on this page.

- ***Filing a Complaint***. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

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Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules with respect to the use or disclosure of protected health information in the categories listed below.	
Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use and/or (2) retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or	FL, IL, IN, LA, NV, WY

underwriting purposes.	

HIV / AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse-related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Financial Information Privacy Notice

Effective: April 14, 2003

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

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*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; United HealthCare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; United HealthCare Service LLC; United Medical Resources, Inc.