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Submission Date:		Dept Action Date: 1/9/04		
Document Form Number	Doc Type ("Policy," etc)	Document Coverage	Department Action	Fee
1. <i>GHC-500-04-CA</i>	<i>Certificate</i>	<i>> HMS</i>	<i>> AUT</i>	
2. <i>GHC-LRG-SOB-04-CA</i>	<i>Schedule of Benefits</i>			
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INSTRUCTIONS: Complete the part of the form to the left of the double vertical line. Enter one document to a numbered line. Use additional formsets if necessary. Be accurate - the copy of this form that we return to you will be your only record of our action on your submission. THIS IS NOT A BILL - DO NOT PAY. YOU WILL RECEIVE A SEPARATE FILING FEE INVOICE SHORTLY; REMIT FEES ONLY WITH THAT INVOICE.			Total \$	Cont'd on _____ Pages

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LEGAL & REG. AFFAIRS

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
3120 WEST LAKE CENTER DRIVE
Santa Ana, California 92704

GROUP HEALTH INSURANCE CERTIFICATE

Pacificare Life and Health Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing insurance for certain eligible Covered Persons. The Certificate describes the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the Certificate if you are eligible for insurance under the provisions of the Policy.

The Certificate is not a contract of insurance and only summarizes the primary provisions of the Policy. The Certificate supersedes and replaces any similar certificate that the Company previously issued to you.

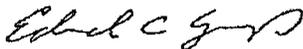
The Certificate is valid only if it includes your Schedule of Benefits.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

YOUR OUT-OF-POCKET COSTS MAY BE LOWER WHEN USING OUR PARTICIPATING PROVIDERS. PLEASE CONSULT THE SCHEDULE OF BENEFITS FOR ADDITIONAL INFORMATION.

Provider Directories may be obtained from the Administrator.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY



Edward C. Cymerys, President

Table of Contents

Section One:		Updating Your Enrollment Information	[#]
[Your Medical Benefits]	[#]	Ending Coverage (Termination of Benefits)	[#]
[Pre-Authorization Requirements]	[#]	Total Disability	[#]
[Inpatient Benefits]	[#]	Coverage Options Following Termination	[#]
[Outpatient Benefits]	[#]	Federal COBRA Continuation Coverage	[#]
[Limitations of Benefits and Exclusions]	[#]	California Continuation Coverage after COBRA	[#]
Section Two:		Extending Your Coverage: Converting to an Individual Conversion Plan	[#]
[Payment Responsibility]	[#]	Certificate of Creditable Coverage	[#]
[Claims Policies and Procedures]	[#]	Uniformed Services Employment and Reemployment Rights Act	[#]
[Claims Processing]	[#]	Section Four:	
[Notice of Claim]	[#]	Overseeing Your Health Care	[#]
[Proof of Loss]	[#]	How the Company Makes Important Health Care Decisions	[#]
[Time of Payment of Claims]	[#]	Authorization, Modification and Denial of Health Care Services	[#]
[Legal Actions]	[#]	Assessment of New Technologies	[#]
[Physical Examinations]	[#]	Utilization Criteria	[#]
[Additional PPO Provisions]	[#]	What to Do if a Covered Person Has a Problem or Grievance	[#]
[Coordination of Benefits]	[#]	Appealing a Health Care Decision	[#]
[Order of Benefit Determination Rules]	[#]	Quality of Care Review	[#]
[Effect on Benefits]	[#]	The Appeals Process	[#]
[Right to Receive and Release Information]	[#]	Urgent Requests	[#]
[Reimbursement of Payment]	[#]	Binding Arbitration	[#]
[Right of Recovery]	[#]	Experimental or Investigational Treatment	[#]
[Third Party Liability and Non-Duplication of Benefits]	[#]	Independent Medical Review	[#]
Section Three:		Eligibility for Independent Medical Review	[#]
Covered Person Eligibility	[#]	Independent Medical Review Procedures	[#]
Who is a Covered Person?	[#]	Claims Against Participating Providers	[#]
Eligibility	[#]	ERISA Rights	[#]
Open Enrollment	[#]	Section Five:	
Adding Dependents to Your Coverage	[#]	Definitions	[#]
Continuing Coverage for Students and Disabled Dependents	[#]		
Late Enrollment	[#]		

WELCOME TO PACIFICARE

The Company provides health care benefits to Covered Persons who have properly enrolled and meet the Employer's eligibility requirements. To learn more about these requirements, see Section Three: Covered Person Eligibility.

WHAT IS THIS PUBLICATION?

This publication is called a *Certificate of Coverage (Certificate)*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see Section Five: Definitions.

Whether You are the Insured Person for this coverage or enrolled as a Dependent, your *Certificate* and *Schedule of Benefits* are key to making the most of your coverage.

WHAT ELSE SHOULD I READ TO UNDERSTAND MY BENEFITS?

Along with reading this publication, be sure to review your *Schedule of Benefits* and any supplemental benefit materials. Your *Schedule of Benefits* provides the details of your particular health plan, including any Deductibles, Copayments or Coinsurance that you may have to pay when receiving a health care service. Together, these documents explain your coverage.

WHAT IF I STILL NEED HELP?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to contact our Customer Service Department at:

- 1-866-316-9776 from 7:00 a.m. to 9:00 p.m. Monday through Friday)
- by accessing our customer service web site at [ppocustomerservice@phs.com

NOTE: Your *Certificate* and *Schedule of Benefits* provide the terms and conditions of your benefits and all applicants have a right to view these documents prior to enrollment. These forms should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may also correspond with the Company at the following address:

PacificCare Health Plan Administrators
P.O. Box 6099
Cypress, California 90630
1-866-316-9776

PacificCare's website is:
www.pacificcare.com

ADMINISTRATORS

Certain provisions of the Certificate are administered by one or more of the Company's Administrators. They are as follows:

FOR PAYMENT OF CLAIMS, ELIGIBILITY, AND BENEFITS VERIFICATION:

PacificCare Health Plan Administrators
P.O. Box 6099
Cypress, California 90630
1-866-316-9776

FOR PRE-AUTHORIZATION OF TREATMENT OR SERVICES:

1-866-863-9776

All inquiries and notifications required by the terms and conditions of the Policy are to be mailed or phoned to the Company's Administrator. Notification requirements to the Company are fulfilled by contacting the Company's Administrator in this manner.

SECTION ONE

Your Medical Benefits

- Pre-Authorization Requirements
- Inpatient Benefits
- Outpatient Benefits
- Limitations and Exclusions

This section explains your medical benefits, including what is and isn't covered by the Company. All Covered Services must be Medically Necessary as determined by the Company. If You have any questions as to whether a service or supply is a Covered Service, please consult this Certificate or contact Us at 1-866-316-9776. Our Customer Service Department can assist You in determining Your benefits. The Company will evaluate submitted Claims for Medical Necessity, and benefit payments may be adjusted or declined consistent with the evaluation findings. For any Deductibles, Copayments or Coinsurance that may be associated with a benefit, you should refer to your Schedule of Benefits. Some services require Pre-Authorization, have limitations, or are excluded from coverage. Please consult your Schedule of Benefits and this Section One for an explanation of your Medical Benefits, as well as the Pre-Authorization provisions and the Limitations and Exclusions Section of this Certificate. You can also find some helpful definitions in Section Five at the back of this Certificate.

If a specific service or supply is not included in this Section One, Your Medical Benefits, or in any supplemental Benefit Rider purchased by the Covered Person's Employer, it is not a Covered Service and no benefits will be provided under the Policy.

YOUR MEDICAL BENEFITS

I. PRE-AUTHORIZATION REQUIREMENTS

Covered Persons must comply with the notification requirements and obtain Pre-Authorization as outlined below to avoid a reduction in benefits under the Policy. The Covered Person must provide the necessary information for review by either calling (866) 863-9776 or submitting the information in writing.

FAILURE TO PRE-AUTHORIZE SERVICES. Failure to comply with the Pre-Authorization Requirements for specified services will result in a reduction of the Benefits Payable by the Company for Covered Services as shown on the Schedule of Benefits. Any additional Covered Expenses that a Covered Person has to pay due to failure to comply with Pre-Authorization Requirements, will not apply toward the Covered Person's Calendar Year Deductible or

Coinsurance Maximum.

EMERGENCY. Notification of Emergency Inpatient admissions must be made to the Company within two (2) business days of admission to a Hospital or Facility.

NON-EMERGENCY. Pre-Authorization must be obtained from the Company three (3) business days before the actual date of service for all scheduled Non-Emergency admissions to a Hospital or Facility and for specified Outpatient procedures and services. The following Non-Emergency Services require Pre-Authorization:

Inpatient Services:

- ELECTIVE/SCHEDULED MEDICAL ADMISSIONS
- ACUTE REHABILITATION ADMISSIONS
- SUB-ACUTE ADMISSIONS
- SKILLED NURSING FACILITY (SNF) ADMISSIONS
- LONG TERM ACUTE CARE FACILITY ADMISSIONS
- ADMISSIONS FOR ALCOHOL, DRUG, AND/OR SUBSTANCE ABUSE
- MENTAL ILLNESS ADMISSIONS
- TRANSPLANTS
- CLINICAL TRIALS

-SCHEDULED SURGICAL ADMISSIONS FOR THE FOLLOWING SERVICES/PROCEDURES:

- Orthognathic Surgery
- Pain Management
- Reconstructive Surgery
- Spinal Surgery
- Total Joint Replacement
- Uvulopalatopharyngoplasty (UPPP)
- Vein Procedures

Outpatient Services:

- Air Ambulance Transport
- Cardiac Rehabilitation
- Clinical Trials
- Dental Anesthesia
- External Counterpulsation (EECP)
- Home Health Care (HHC)
- Hyperbaric Oxygen Therapy
- Injectable Drugs/Home Infusion
- Pain Management Programs
- PET Scans
- Proton Beam Therapy
- Pulmonary Rehabilitation
- Sleep Studies
- Transplant Evaluations and Related Services

The Company will review submitted medical information to determine the Medical Necessity and appropriateness of the service, as defined by the Policy. Review determinations are generally made within three (3) business days of receipt of complete medical information. Services deemed not Medically Necessary will not be eligible for benefits under the Policy.

II. INPATIENT BENEFITS

1. **Alcohol, Drug or Other Substance Abuse Detoxification** - Alcohol, Drug or Other Substance Abuse Detoxification is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.
2. **Blood and Blood Products** - Blood and blood products are covered. Autologous (self donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
3. **Cancer Clinical Trials** - Covered Services include all Routine Patient Care Costs related to an approved therapeutic phase I, phase II, phase III, or phase IV Cancer Clinical Trial for a Covered Person diagnosed with cancer and whose treating Physician recommends that participation in the clinical trial has a meaningful potential to benefit the Covered Person.
Covered Expenses includes Routine Patient Care Costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:
 - Health care services typically provided absent a clinical trial.
 - Health care services required solely for the provision of the investigational drug, item, device, or service.
 - Health care services required for the clinically appropriate monitoring of the investigational item or service.
 - Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
 - Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

For purposes of this Covered Service, Routine Patient Care Costs do not include the costs associated with the provision of any of the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

- Services other than health care services, such as travel, housing, companion expenses, and other non clinical expenses, that an insured may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage.
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

An approved Cancer Clinical Trial shall either (1) involves a drug that is exempt under federal regulations from a new drug application or (2) is approved by one of the following:

- One of the National Institutes of Health.
- The federal Food and Drug Administration, in the form of an investigational new drug application.
- The United States Department of Defense.
- The United States Veterans' Administration.

A Cancer Clinical Trial with endpoints defined exclusively to test toxicity is not a Covered Expense.

All services must be Pre-Authorized by the Company's Medical Director or designee. A Covered Person must select a Provider performing a Cancer Clinical Trial with the protocol recommended by the Covered Person's Provider within the Covered Person's domicile state. If there is no Provider offering the Cancer Clinical Trial with the same protocol as the one the Covered Person's treating Provider recommended in the domicile state, the Covered Person may select a Cancer Clinical Trial outside the domicile state but within the United States of America.

The Company is required to pay for the services covered under this benefit at the rate agreed upon by the Company and a Participating Provider, minus any applicable Coinsurance, Copayments or Deductibles. In the event the Covered Person participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate the Company negotiates with Participating Providers, the Covered Person will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by the Company with Participating Providers, in addition to any applicable Coinsurance, Copayments or Deductibles.

4. Hospice Services – Hospice services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of 6 months or less, if the Sickness follows its natural course. Hospice services are provided as determined by the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered

Person, the Physician, a registered nurse and a social worker. Hospice services are provided in an appropriately licensed hospice facility when the Covered Person's interdisciplinary team has determined that the Covered Person's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver, when it is necessary to relieve the family members or other persons caring for the Covered Person ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Hospice services include skilled nursing services, certified home health aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Covered Person to maintain activities of daily living and basic functional skills.

5. **Inpatient Hospital /Acute Care Services** – Inpatient Hospital Services authorized by the Company are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the Hospital-based pathologist, radiologist, or anesthesiologist, emergency room physician, emergency room and other miscellaneous Hospital charges for care and treatment.
6. **Inpatient Physician Services** – Services from Physicians, including specialists and other licensed health professionals are covered while the Covered Person is hospitalized as an inpatient.
7. **Inpatient Rehabilitation Care** – Rehabilitation services that must be provided in an inpatient rehabilitation facility are covered. Rehabilitation services are the combined and coordinated use of medical, social, educational, and vocational measures for training and retraining individuals disabled by Sickness or Injury. A rehabilitation facility provides comprehensive rehabilitation services under the supervision of a Physician to inpatients with physical disabilities.
8. **Mastectomy, Breast Reconstruction after Mastectomy and Complications from Mastectomy** – Medically Necessary Mastectomy and lymph node dissection are covered, including prosthetic devices and/or Reconstructive Surgery to restore and achieve symmetry for the Covered Person incident to the mastectomy. The length of a Hospital stay is determined by the attending Physician and surgeon in consultation with the Covered Person, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent Reconstructive Surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

9. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage and complications of pregnancy or childbirth.

- Alternative birthing center services are covered when the facility is connected with or to a Hospital facility.
- Nurse midwife services are covered.

A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient Hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48 or 96 hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

10. **Newborn Care** - Postnatal Hospital Services and special care nursery services are covered, including elective circumcision when performed in the Hospital before discharge or within 6 months of birth if delayed for medical reasons.

11. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Covered Person and the transplant is performed at a National Preferred Transplant Network or other Company Authorized Transplant Facility.

- Transportation is limited to the transportation of the Covered Person and one escort to a National Preferred Transplant Network or other Company Authorized Transplant Facility greater than 60 miles from the Covered Person's Primary Residence. Transportation and other non-clinical expenses of the living donor are excluded, and are the responsibility of the Covered Person, who is the recipient of the transplant.
- Food and housing is not covered unless the National Preferred Transplant Network or other Company Authorized Transplant Facility is located more than 60 miles from the Covered Person's Primary Residence, in which case food and housing is limited to cover both the Covered Person and escort, if any (excludes liquor and tobacco). Food and housing expenses are limited to \$125 per day, with a lifetime maximum of \$5,000 if the transplant services are not rendered at a National Preferred Transplant Network Facility, and \$125 per day if the transplant services are rendered at a National Preferred Transplant Network Facility. Food and housing expenses are not covered for any day a Covered Person is not receiving transplant services.
- Listing of the Covered Person at a second National Preferred Transplant Network or other Company Authorized Transplant Facility is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Covered Person is accepted for listing by both facilities. In these cases, organ transplant listing is limited to two selections between the National

Preferred Transplant Network or other Company Authorized Transplant Facilities. If the Covered Person is dual listed, his or her coverage is limited to the actual transplant at the second facility. The Covered Person is responsible for any duplicated diagnostic costs incurred at the second facility.

Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Covered Person is the intended recipient. A National Preferred Transplant Network or other Company Approved Transplant Facility must conduct the computerized searches.

A 12-month exclusion period will apply to all Covered Persons initially enrolling under the Policy for all covered transplant services. The exclusion period will be reduced or eliminated based on prior creditable coverage, which must be continuous with no lapses greater than sixty days. Every month of creditable coverage will reduce the 12-month exclusion period by one month.

Credit for prior creditable coverage will be given if transplant services were covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan.

12. Reconstructive Surgery – Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.
13. Skilled Nursing/Subacute and Transitional Care – Skilled Nursing Care and Skilled Rehabilitation Care are covered, including facility room and board. Skilled nursing care and skilled rehabilitation care is provided directly by or under the direct supervision of licensed Providers. A skilled nursing facility is a comprehensive freestanding facility or a specially designed unit within a Hospital licensed by the state in which it is doing business to provide skilled nursing care. Subacute and transitional care are levels of skilled care needed by a Covered Person who does not require Hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of the patients in a skilled nursing facility.

III. OUTPATIENT BENEFITS

1. Alcohol, Drug or Other Substance Abuse Detoxification - Alcohol, Drug or Other Substance Abuse Detoxification is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly

probable.

2. **Ambulance** – The use of an ambulance (land or air) is covered - when the Covered Person, as a Prudent Layperson, reasonably believes that the medical or psychiatric condition requires Emergency Services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the "911" emergency response system. Ambulance transportation is limited to the nearest available emergency facility having the expertise to stabilize the Covered Person's Emergency Medical Condition. Use of an ambulance for non-Emergency Services is limited to inter-facility transfers between two Hospitals, between a Hospital and a non-custodial Skilled Nursing Facility, or between a non-custodial Skilled Nursing Facility and dialysis or radiation therapy.
3. **Blood and Blood Products** - Blood and blood products are covered. Autologous (self donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
4. **Cancer Clinical Trials** – Please refer to the benefit described above under Inpatient Cancer Clinical Trials. Outpatient services Coinsurance and/or Deductibles apply for any Cancer Clinical Trials services received on an outpatient basis according to the Coinsurance on your Schedule of Benefits for that specific outpatient service. The Company is required to pay for the services covered under this benefit at the rate agreed upon by the Company and a Participating Provider, minus any applicable, Coinsurance or Deductibles. In the event the Covered Person participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate the Company negotiates with Participating Providers, the Covered Person will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by the Company with Participating Providers, in addition to any applicable Coinsurance or Deductibles.

Any additional expenses the Covered Person may have to pay beyond the Company's negotiated rate as a result of using a Non-Participating Provider do not apply to the Covered Person's annual Coinsurance Maximum.

5. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services" and "Oral Surgery and Dental Services: Dental Treatment Anesthesia" provisions below.
6. **Diabetic Management and Treatment** - Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and be prescribed by a Provider acting within the scope of his/her licensure.
7. **Diabetic Self-Management Items** - Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Covered Person, including but not necessarily limited to:

blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes, podiatry services and devices to prevent or treat diabetes related complications. Visual aids are covered for Covered Persons who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses.

8. **Dialysis** - Acute and chronic dialysis services and supplies are covered. For chronic dialysis, application for Medicare Part A and Part B coverage must be made.
9. **Durable Medical Equipment (Rental, Purchase or Repair)** - Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or sickness of the Covered Person, and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, hospital beds and standard oxygen delivery systems. Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Covered Person's physical condition. The Company has the option to repair or replace Durable Medical Equipment items.
10. **Home Health Care** - Part-time or intermittent services, consisting of skilled nursing care and skilled rehabilitation care, are covered in the home. Part-time intermittent skilled nursing services are services provided by (i) a registered nurse or licensed vocational nurse; (ii) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (iii) physical, occupational or speech therapy; and drugs and medications and related pharmaceutical services, medical supplies, infusion therapy drugs and lab services prescribed by a physician to the extent such charges or costs would be covered under the plan if the Covered Person had remained in the hospital.
11. **Hospice Services** - Hospice services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of 6 months or less, if the sickness follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered Person, the Covered Person's physician, a registered nurse, a social worker and a spiritual caregiver.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a Covered Person requires continuous care to achieve palliation or management of acute medical symptoms.

12. **Infusion Therapy** - Infusion therapy means the therapeutic use of drugs or other substances, prepared or compounded, and administered by a Provider and given to a Covered Person through a needle or catheter. Services must be provided in the Covered Person's home or an institution that is not a Hospital or is not primarily engaged in providing skilled nursing or rehabilitation services. (For example, board and care, custodial care facility and assisted living facility.) Infusion therapy is only covered as part of a treatment plan prescribed by a Physician.
13. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** - Outpatient injectable medications are covered. Self-injectable medications are covered when a Covered Person is trained in the use of the medication and the medication is prescribed by a Physician for the treatment of a Sickness or Injury. Injectable Drugs and Self-Injectable Medications do not include insulin.
14. **Laboratory Services** -- Diagnostic and therapeutic laboratory services are covered, limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), and organ or disease oriented panels. Components of the above tests are also covered if ordered individually.
15. **Maternity Care, Tests, and Procedures** - Physician visits, laboratory services (including the California Department of Health Services' expanded alpha fetoprotein (AFP) program), and radiology services are covered for prenatal and post-partum maternity care
 - Nurse midwife services are covered by midwives practicing within the scope of his/her license.
 - Genetic testing and Counseling are covered as part of an amniocentesis or chorionic villus sampling procedure.
16. **Medical Supplies and Materials** - Medical supplies and materials necessary to treat an Sickness or Injury are covered when used or furnished while the Covered Person is being treated in the Provider's office; in the home by a licensed healthcare professional; or used in conjunction with durable medical equipment for proper functioning of the durable medical equipment.
17. **Neuromuscular Skeletal Services** - Services of a licensed, registered or certified Provider for the treatment of Neuromuscular Skeletal Disorders with heat, cold, exercise, electricity, ultraviolet radiation and manipulation of the spine, neck or joints, or massage used by the Provider for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion are covered. These services must be prescribed by a Physician.
18. **Oral Surgery and Dental Services** - Emergency Services for stabilization of an

acute injury to sound natural teeth, the jawbone or surrounding structures are covered. Other covered Oral Surgery and Dental Services include:

- Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint ("TMJ") syndrome;
- Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck;
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.

19. Oral Surgery and Dental Services: Dental Treatment Anesthesia - Anesthesia and associated facility charges for dental procedures provided in a Hospital or outpatient surgery center are covered when: (1) the Covered Person's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or outpatient surgery center setting and one of the following criteria is met:

- The Covered Person is under seven years of age;
- The Covered Person is developmentally disabled, regardless of age; or
- The Covered Person's health is compromised and general anesthesia is Medically Necessary, regardless of age.

The Covered Person's dentist must obtain Pre-Authorization from the Company.

20. Outpatient Medical Rehabilitation Therapy - Covered services include physical therapy, speech therapy and occupational therapy for the treatment of a Sickness or Injury, provided by a licensed healthcare professional or under the direct supervision of a licensed healthcare professional.
21. Outpatient Surgery - Short stay, same day or other similar outpatient surgery services (of less than 24 hours) are covered when provided as a substitute for inpatient care at a Hospital or licensed free-standing outpatient surgical center.
22. Phenylketonuria ("PKU") Testing and Treatment - Testing for Phenylketonuria ("PKU") is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease.
23. Physician Office Visits - Covered Services for the detection and treatment of an Injury or Sickness during or associated with a physician's office visit include:

- Allergy testing services and supplies for the determination of the appropriate course of allergy treatment
- Allergy treatment services including serum
- Antibiotic injections
- Breast and Pelvic Cancer Screening and Diagnosis. Services for the screening and diagnosis of breast cancer, including an annual clinical breast exam for age 40 and above and an annual Pelvic examination with Pap Smear. Mammography for screening or diagnostic purposes is covered as follows:
 - Baseline mammogram for women age 35 to 39; a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's Physician's recommendation; and a mammogram every year for women age 50 and over.
- Colorectal Cancer Screening, to include an examination for Covered Persons age 50 and over, and who have an increased risk of developing colon cancer as determined by a Physician. This screening may include the following:
 1. a fecal occult blood test performed annually; and
 2. a flexible sigmoidoscopy performed every (5) five years or a colonoscopy performed every (10) ten years.
- Detection of Osteoporosis using bone mass measurement used for the detection of low bone mass and for the determination of the person's risk of osteoporosis and fractures associated with osteoporosis. Osteoporosis detection services are Covered Services when provided to the following qualified Covered Persons:
 - a. postmenopausal women who are not receiving estrogen replacement therapy;
 - b. individuals with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures;
 - c. individuals who are receiving long-term glucocorticoid therapy; or
 - d. individuals who are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- Diagnostic laboratory services limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), and organ or disease oriented panels. Components of the above tests are also covered if ordered individually.
- Diagnostic radiology services including but not limited to standard x-ray films for the diagnosis of a Sickness or Injury (except specialized scanning, imaging and diagnostic procedures specifically excluded in this section).
- Prostate Screening - Evaluations for the screening and diagnosis of prostate

cancer is covered to include an annual screening in men age 50 and over, and in men age 40 and over who have an increased risk of developing prostate cancer as determined by a Physician. This screening may include, but is not limited to the following: prostate-specific antigen testing and digital rectal examination.

Periodic Health Evaluations (through age 18):

For Children through age 18, Periodic Health Evaluations are covered. This evaluation includes the following:

- Age appropriate Immunizations for children are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States.¹
- Laboratory tests in conjunction with the health evaluation including screening for blood lead levels.
- Height and weight evaluations
- Vision screening

Periodic Health Evaluations (age 19 and over):

Periodic Health Evaluations are covered, and shall not exceed the limits shown on the Schedule of Benefits. This benefit includes the following health screenings:

- Hearing Screening - Routine hearing screening by a Provider is covered to determine hearing loss.
- Vision Screening - Eye health assessment and screening by a Provider for high-risk individuals is covered. An annual retinal examination is covered for Covered Persons with diabetes.
- Immunizations for adults are covered consistent with the most current recommendations of the Centers for Disease Control and Prevention (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices.
- Diagnostic laboratory services (age and gender appropriate) in conjunction with an office visit
- Weight Evaluation

¹ This is jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians.

The Physician Office Visit benefit does not include or apply to:

- Specialized scanning, imaging, and diagnostic procedures such as CT, SPECT, PET, MRA and MRI, EKG, EEG, EMG and nuclear medicine studies.
- Ultrasounds, except for maternity care
- Outpatient office based surgery
- Injectable or Intravenous drugs (other than antibiotics, Immunizations, and allergy serum)
- Any service shown on the Schedule of Benefits as not applicable or not covered.

24. **Prosthetics and Corrective Appliances** - Prosthetics (except for bionic or myoelectric as explained below) are covered.
- Custom-made or Custom-fitted Corrective Appliances are covered.
 - Replacements, repairs and adjustments to Corrective Appliances and Prosthetics are limited to normal wear and tear or because of a significant change in the Covered Person's physical condition.
25. **Radiation Therapy** - Services for radiation therapy are covered.
26. **Radiology Services** - Including but not limited to Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of a Sickness or Injury are covered.
27. **Reconstructive Surgery** - Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.
28. **Severe Mental Illness Services** - Only services to treat Severe Mental Illness for adults and children, and Serious Emotional Disturbances of a Child are covered. Please refer to Schedule of Benefits for information on how to obtain coverage.
29. **Specialized Footwear** - Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Covered Person with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace.
30. **Specialized Scanning, Imaging and Diagnostic procedures** - such as CT, SPECT, PET, MRA and MRI, ultrasound, EKG, EEG, EMG and nuclear medicine

studies are covered. Ultrasounds are also covered as part of the Maternity benefit.

31. **Sterilization** – Benefits include Sterilization procedures including, but not limited to, tubal ligations and vasectomies.
32. **Urgent Care Services** - Benefits include Covered Services from an Urgent Care Facility and are provided as shown in the Schedule of Benefits.

III. LIMITATIONS OF BENEFITS AND EXCLUSIONS

Unless described as a Covered Service in an attached supplemental Benefit Rider, all services and benefits described below are limited or excluded from coverage under this Certificate. (NOTE: Additional limitations and exclusions may be contained in the supplemental Benefit Riders.)

LIMITATIONS OF BENEFITS

1. **Biofeedback** - Biofeedback services are not covered except for bladder rehabilitation.
2. **Blood and Blood Products** – The costs of transportation and processing for autologous, donor-directed or donor-designated blood are not covered in excess of the cost of a unit of blood from a recognized blood bank organization.
3. **Bone Marrow and Stem Cell Transplants** - Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel. Unrelated Donor Computer Searches for Covered Persons who require a bone marrow or stem cell transplant are limited to the donor maximum for the Covered Person's Transplant Benefit. Donor searches are only covered when performed by a Provider included in the National Preferred Transplant Network Facility or other Company Approved Transplant Facility. Covered Services are subject to the limitations shown in the Schedule of Benefits.
4. **Chiropractic Services** - Services are limited to Neuromuscular Skeletal Services as described in the benefit section of this Certificate.
5. **Custodial Care** - Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed hospice facility incident to a Covered Person's terminal illness as described in the explanation of Hospice Services in the Medical Benefits Section of this Certificate.
6. **Diabetic Self-Management Items** – Covered Persons must have prescription drug coverage for insulin, glucagon and other diabetic medications to be covered.
7. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or Investigational Procedures, Items and Treatments are not covered unless required by an external, independent review panel as described in Section 4, *Health Care Decisions*, or as described under "Cancer Clinical Trials" in the "Inpatient Benefits" and "Outpatient Benefits" sections of this Certificate. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a Company Medical Director, or his or her designee. For the purposes of this Certificate,

any studies, tests, drugs, procedures, treatment or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as Experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by the Company in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this plan, include but are not limited to the following:

- a. The Covered Person's medical records;
- b. The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
- c. Any informed consent document the Covered Person, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- d. The published authoritative medical and scientific literature regarding the drug, device, treatment, or procedure;
- e. Expert medical opinion;
- f. Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman);
- g. Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research ("AHCPR");

h. The Company Technology Assessment Committee Guidelines.

8. **Foot Orthotics /Footwear** - Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered. However, specialized footwear may be covered for Covered Persons with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace. (*Refer to Prosthetics and Corrective Appliances Benefit in Section 1, Your Medical Benefits*).
9. **Genetic Testing and Counseling** - Genetic testing solely to determine the gender of a fetus is not covered. Genetic testing and counseling are not covered when done for non-medical reasons or when a Covered Person has no medical indication or family history of a genetic abnormality. General testing and counseling are not covered to screen newborns, children or adolescents to determine their carrier status for inheritable disorders when there would be no immediate medical benefit or when the test results would not be used to initiate medical interventions during childhood. Genetic testing and counseling are not covered except when determined by the Company Medical Director or designee to be Medically Necessary to treat the Covered Person for an inheritable disease. Genetic testing of non-Covered Persons is not covered.
10. **Hearing Aids and Hearing Devices** - Audiology services performed only to determine the need for, or the appropriate type of, hearing aid are not covered.
11. **Institutional Services and Supplies** - Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies furnished by a facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered.
12. **Mental Illness Services** - Mental Illness Services are not covered except for diagnosis and treatment of Severe Mental Illness for adults and children, and for diagnosis and treatment of Serious Emotional Disturbances of a Child.
13. **Nutritional Supplements or Formulas** - Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of "Phenylketonuria (PKU) Testing and Treatment."
14. **Off Label Drug Use** - Off Label Drug Use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off label self-injectable drugs or infusion therapy, is not covered except as required by state law or as follows: If the self-injectable drug is prescribed for Off Label Use, the drug and its administration is covered only when the following criteria are met:
 - The drug is approved by the FDA;
 - The drug is prescribed by a Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
 - The drug is Medically Necessary to treat the condition;
 - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Medical Association *Drug Evaluations*, The American Hospital Formulary Service *Drug*

Information, The United States Pharmacopoeia Dispensing Information, Volume 1, or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective;

- The drug is covered under the injectable drug benefit described in the outpatient benefits section of this Certificate
 - Nothing in this section shall prohibit the Company from use of a formulary, Coinsurance, technology assessment panel or similar mechanism as a means for appropriately managing the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.
15. **Organ Donor Evaluation and Services** - Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Covered Person. Covered Services for living donors are limited to transplant-related clinical services once a donor is identified. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. Pre-transplant living donor evaluation services are subject to the Donor Maximum shown in the Schedule of Benefits.
16. **Reconstructive Surgery** - Reconstructive Surgeries are not covered under the following circumstances:
- a. When there is another more appropriate surgical procedure that has been offered to the Covered Person; or
 - b. When only a minimal improvement in the Covered Person's appearance is expected to be achieved.
17. **Recreational, Lifestyle, Educational or Hypnotic Therapy** - Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing, is not covered except for Diabetic Self Management training.
18. **Rehabilitation Services and Therapy** - Rehabilitation services and therapy are either limited or not covered, as follows:
- Speech, occupational or physical therapy is not covered when medical documentation does not support the Medical Necessity because of the Covered Person's inability to progress toward the treatment plan goals or when a Covered Person has already met the treatment goals.
 - Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined Sickness, Injury or surgery (for example, cleft palate repair).
 - Exercise programs are only covered when they require the direct supervision of a licensed Physical Therapist and are part of a Physician's treatment plan.
 - Aquatic/pool therapy is not covered unless conducted by a licensed Physical Therapist and part of a Physician's treatment plan.
 - Massage therapy is not covered except as part of Neuromuscular Skeletal Services benefit described in the outpatient benefits section of this Certificate.

19. **Respite Care** - Respite Care is not covered, unless part of an authorized Hospice Plan and is necessary to relieve the primary caregiver in a Covered Person's residence. Respite care is covered only on an occasional basis, not to exceed five consecutive days at a time.
20. **Transplant Services** - Transplant services are covered when the transplant is performed at a National Preferred Transplant Network or other Company Authorized Transplant Facility.
21. **Transportation** - Transportation is not a covered benefit except as covered under the Ambulance and Organ Transplant Services benefits in this Certificate.
22. **Veterans' Administration Services** - Veterans' Administration (VA) services are not covered, except for Emergency Services received in a VA facility.

EXCLUSIONS

- Services that are not Medically Necessary, as defined in the Definitions section of this Certificate are not covered.
 - Services not specifically included in Section 1, *Your Medical Benefits*, or any supplemental Benefit Rider purchased by the Covered Person's Employer, are not covered.
 - Services rendered prior to the Covered Person's effective date of enrollment or after the effective date of disenrollment are not covered.
 - The Company does not cover the cost of services provided in preparation for a non-Covered Service. Additionally, the Company does not cover the cost of routine follow-up care for non-Covered Services (as recognized by the organized medical community in the State of California). The Company will cover services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.
1. **Acupuncture and Acupressure** - Acupuncture and Acupressure are not covered; except that an acupuncturist may perform covered services when he/she is practicing within the scope of his/her licensure.
 2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** - Air conditioners, air purifiers and other environmental equipment are not covered.
 3. **Alcoholism, Drug and Other Substance Abuse Rehabilitation** - Alcoholism, drug and other substance abuse rehabilitation services, including methadone treatment, is not covered.
 4. **Ambulance** - Ambulance services are not covered if they are not Medically Necessary or if used as a convenience for the Covered Person or their family. Wheelchair transportation services (e.g., a specially designed van or taxi) and personal transportation costs such as gasoline costs for a private vehicle or taxi fare are also not covered.
 5. **Behavior Modification and Non Crisis Mental Health Counseling and Treatment** - Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.]

6. Communication Devices – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered.
7. Complementary and Alternative Medicine - Complementary and Alternative Medicine are not covered.
8. Cosmetic Services and Surgery – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Covered Person's psychological or psychiatric condition.
9. Dental Care, Dental Services, Dental Appliances and Orthodontics – Except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care refers to all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment; plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures.
10. Dental Treatment Anesthesia - Dental treatment anesthesia provided or administered in a dentist's office is not covered.
11. Diagnostic Admissions - Services in connection with a Hospital stay primarily for diagnostic tests which could have been performed on an outpatient basis are not covered.
12. Disabilities Connected to Military Services - Treatment in a government facility for a Sickness or Injury connected to military service that the Covered Person is legally entitled to receive through a federal governmental agency, and to which the Covered Person has reasonable access, is not covered.
13. Drugs and Prescription Medication (Outpatient) – Outpatient drugs and prescription medications are not covered unless provided by a supplemental Benefit Rider. Refer to benefits, "Injectable Drugs" and "Infusion Therapy" for benefit coverage. Pen devices for the delivery of medication, other than insulin, are not covered.
14. Durable Medical Equipment – Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Covered Person, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling.
15. Educational Services for Developmental Delays and Learning Disabilities – Educational services to treat developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be

expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training.

16. **Elective Enhancements** – Procedures, services, drugs and supplies for elective, non-Medically Necessary enhancements to normal body parts are not covered.
17. **Exercise Equipment and Services** - Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs, gyms, home exercise equipment or swimming pools, even if ordered by a health care professional.
18. **Eye Wear and Corrective Refractive Procedures** - Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered unless provided by an attached supplemental Benefit Rider. Surgical and laser procedures to correct or improve refractive error are not covered unless provided by an attached supplemental Benefit Rider.
19. **Family Planning** - Family planning is not covered unless provided by a supplemental Benefit Rider. Family planning is services and supplies related to a surgical or medical voluntary termination of pregnancy. This exclusion does not apply to therapeutic abortions where the mother's life is in danger or the fetus is not viable.
20. **Foot Care** - Routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
21. **Government Services and Treatment** - Any services that the Covered Person receives from a local, state or federal governmental agency are not covered.
22. **Hearing Aids and Hearing Devices** - Hearing aids and non-implantable hearing devices are not covered. Hearing aid supplies are not covered. Implantable hearing devices including Cochlear devices are not covered, unless provided by an attached supplemental Benefit Rider.
23. **Immunizations** - Travel and/or required work-related immunizations are not covered.
24. **Infertility Reversal** - Reversals of sterilization procedures are not covered.
25. **Infertility Services** - Infertility Services are not covered, unless provided by an attached supplemental Benefit Rider.
26. **Maternity Services and Education** - Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.
27. **Morbid Obesity** - Surgical treatment for morbid obesity and services related to this surgery are not covered.
28. **Nurse Midwife Services** - Home Deliveries are not covered. (*Refer to Maternity Care Benefit in Section 1, Your Medical Benefits*).

29. Nursing, Private Duty - Private duty nursing is not covered.
30. Physical or Psychological Examinations - Physical or psychological examinations for court hearings, travel, premarital, pre-adoption or other non-preventive health reasons are not covered.
31. Private Rooms and Comfort Items - Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization, are not covered.
32. Prosthetics and Corrective Appliances - Replacement of lost Prosthetics or Corrective Appliances is not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.
33. Rehabilitation Services and Therapy - Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
34. Services Provided by Family, Relatives or other Household Members - Services in the home or other settings provided by relatives or other household members of Covered Persons are not covered.
35. Services While Incarcerated or Confined - Services required for Injuries or Sicknesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered.
36. Sex Transformations - Procedures, services, medications and supplies related to sex transformations are not covered.
37. Surrogacy - Infertility and maternity services for non-Covered Persons are not covered. Maternity services for a covered person acting as a surrogate are not covered.
38. Vision Training - Vision therapy and ocular training programs (orthoptics) are not covered.
39. Weight Alteration Programs - Weight loss or weight gain programs are not covered.
40. Worker's Compensation - Services payable under Worker's Compensation are not covered.
41. War - Services incurred as a result of declared or undeclared war.
42. Active Military Duty - Services incurred as a result of active military duty.

EXCLUSIONARY PERIOD FOR PRE-EXISTING CONDITIONS. With respect to an Insured Person or a Dependent who was enrolled within 31 days of the date the Person first became eligible for coverage under the Policy, no benefits will be paid for a Pre-Existing Condition for a period of 12 months after the first day of the Waiting Period. With respect to all other Covered Persons, no benefits will be paid for a Pre-Existing Condition for a period of 12 months (18 months for a Late Enrollee) after the Effective Date of coverage for the Covered Person.

The "Exclusionary Period for Pre-Existing Conditions" does not apply to a child who is born or placed for adoption after Your Effective Date of coverage, who is otherwise eligible for coverage, and enrolled within 31 days of the birth or adoption. The "Exclusionary Period for Pre-Existing Conditions" also does not apply to such a child who, as of the last day of a 31 day period beginning on the date of birth or adoption, was covered under other Creditable Coverage unless such child has subsequently had a Significant Break in Coverage.

The "Exclusionary Period for Pre-Existing Conditions" will be reduced by the combined periods of prior Creditable Coverage, if any, applicable to the Covered Person. However, any period of Creditable Coverage occurring prior to a Significant Break in Coverage will not be counted in determining this reduction. The Covered Person must provide satisfactory evidence of Creditable Coverage in order to obtain a reduction in the "Exclusionary Period for Pre-Existing Conditions". You may request such evidence or certification of Creditable Coverage from the prior plan or prior insurer.

SECTION TWO

Payment Responsibility

- Claims Policies and Procedures
- Coordination of Benefits

This section explains Claims payment procedures and related Claims matters. It also explains when The Company needs to coordinate your benefits with another plan.

CLAIMS POLICIES AND PROCEDURES

These procedures must be followed by Covered Persons to obtain payment of benefits under the Policy.

Limitation of Liability. The Company shall not be obligated to pay any benefits under the Policy for any Claims if the proof of loss for such Claim was not submitted within the period provided, unless it is shown that (a) it was not reasonably possible to have submitted the proof of loss within such period and (b) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is not submitted to the Company within 1 year after the date of loss, except in the case of legal incapacity of the Covered Person.

CLAIMS PROCESSING

The Company reviews and evaluates all service benefit payment submissions for Medical Necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the Current Procedural Terminology system coding standards. The Company may adjust or decline benefit payments consistent with the evaluation findings.

NOTICE OF CLAIM

A written notice of Claim must be furnished to the Company within 20 days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

The Company will, upon receipt of notice of Claim, furnish to the Insured Person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the Insured Person shall be deemed to have complied with the requirements of the Policy as to the proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which a Claim is made.

PROOF OF LOSS

GHC-500-04-CA

Written proof of loss must be furnished to the Company at its office within 90 days after the date of the loss. The Company will not reduce or deny a Claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the Company will not accept proof more than 1 year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS

Benefits for incurred medical expenses that are covered under the Policy will be paid upon receipt of a proper Claim by the Company.

Payment of Benefits to Insured Person. All benefits, unless assigned under the Policy, are payable to the Insured Person, whose Injury or Sickness, or whose covered Dependent's Injury or Sickness, is the basis of a Claim.

Death or Incapacity of Insured Person. In the event of the Insured Person's death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Insured Person's estate, the Company may, in its discretion make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Insured Person's care and support.

Assignments. Benefits for Covered Expenses may be assigned by the Covered Person to the person or institution rendering the services. No such assignment will bind the Company prior to the payment of the benefits assigned. The Company will not be responsible for determining an assignment's validity. Payment of assigned benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person and the assignee, is received prior to payment.

LEGAL ACTIONS

Any Person may not bring legal action for benefits against the Company:

1. Until at least 60 days after proof of loss is sent to the Company as required; or
2. More than 3 years after the time for submitting proof has ended.

PHYSICAL EXAMINATIONS

The Company, at its expense, may:

1. have a Covered Person examined, as often as reasonably necessary, while any Claim is pending; and
2. have an autopsy made, where allowed by law, if a Claim for benefits is made.

Additional PPO Provisions

Deductible Carry-Over. Covered Expense applied to a Covered Person's Calendar Year Deductible during the last 3 months of a Calendar Year will apply to that Covered Person's Calendar Year Deductible for the following

GHC-500-04-CA

Calendar Year.

Deductible Takeover. If the Policy is replacing a similar policy that had been issued to the Group Policyholder, any portion of any deductible the Covered Person had satisfied under the replaced plan shall apply to the satisfaction of the Covered Person's Initial Calendar Year Deductible under the Policy. Proof of deductible satisfaction under the replaced plan will be required upon submission of the Initial Claim for benefits to be payable under the Policy.

Family Deductible. When Covered Expenses for all Family Members accrue to the amount indicated on the Schedule of Benefits, no additional Calendar Year Deductible will apply to the other family members for the rest of that Calendar Year.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

The Company may coordinate benefits with benefits available under other similar health insurance policies. Coordination of Benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the Covered Person never receives a total, from all Plans, of more than 100% of Covered Expense Incurred. All benefits provided under the Policy are subject to this coordination provision.

What is a Plan?

A "Plan", as used in this Coordination of Benefits provision, means any of the following policies that provide benefits or services for medical or surgical treatment:

1. group, blanket or franchise insurance coverage;
2. prepaid coverage under service Plan contracts, or under group or individual practice;
3. any coverage under labor-management trustee plans, union welfare plans, Employer organization Plans, or employee benefit organizations Plans;
4. any coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type plans;
5. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a Plan when, by law, its benefits are in excess to those of any private insurance Plan or other non-governmental Plan; or
6. any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of membership in or association with a particular organization or group.

Each Plan, or other arrangement for coverage described above, is a separate Plan. If a Plan has two parts and the coordination of benefits provisions only apply to one part, each part is a separate Plan. However, 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 Coordination of Benefits between those separate contracts.

What is a Covered Expense?

A Covered Expense, as used in this Coordination of Benefits provision, means any expense which is covered by at least one Plan during a Claim Determination Period; however, any expense which is not payable by the primary Plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, pre-admission testing, pre-admission review of Hospital confinement, mandatory Outpatient surgery, etc.) will not be considered a Covered Expense by the secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a [Calendar] [Plan] Year will also be considered a Covered Expense.

ORDER OF BENEFIT DETERMINATION RULES

The following rules determine the order of benefit payment:

1. A Plan without a Coordination of Benefits provision pays before one with such a provision;
2. A Plan which covers a person other than as a Dependent pays before a Plan which covers a person as a Dependent;
3. For a covered Dependent child, the Plan of the parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year pays before the Plan of the parent whose date of birth, excluding year of birth, occurs later in a Calendar Year. To apply, the coordinating Plan must have a similar provision; and
4. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with custody of the child; and
 - c. finally, the Plan of the parent without custody of the child.However, where a court decree orders one parent responsible for the health care expenses of the child, the Plan of that parent pays first.
5. When rules 1. through 4. do not establish the order of benefit determination, the Plan covering the Person for a longer period pays first; however:
 - a. the Plan covering the person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, will pay after any other Plan covering that person as a full-time employee, or Dependent of a full-time employee; and
 - b. if the other Plan does not have an Order of Benefit Determination Rule regarding laid-off or retired employees, then the provisions of rule 5.a. will not apply.

EFFECT ON BENEFITS

Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced when the sum of:

1. the benefits payable for the Covered Expense under this Plan without this provision; and
2. the benefits payable for the Covered Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Covered Expense in a Calendar Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans do not total more than the Covered Expense.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For determining the applicability and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance company or other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

REIMBURSEMENT OF PAYMENT

Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

RIGHT OF RECOVERY

Whenever payments for Covered Expenses exceed the maximum payment necessary to satisfy the Coordination of Benefits provisions, the Company may recover such excess payments. The term "payments for Covered Expenses" includes the reasonable cash value of any benefits provided in the form of services.

THIRD PARTY LIABILITY AND NON-DUPLICATION OF BENEFITS

1. **Third Party Liability.** This provision applies when:
 - a. A Covered Person suffers an Injury or Sickness through the act or omission of another person (the "Third Party"); and
 - b. Benefits are paid under the Policy for that Injury or Sickness.

The Company is entitled to a refund of all benefits paid. The refund must equal the payment for the Injury or Sickness by the Third Party. The Company may file a lien against the Third Party payment. The Covered Person must complete and return any required forms to the Company upon request.

The Covered Person agrees that the Company's rights to reimbursement under the Coordination of Benefits section are the first priority Claim against any Third Party. The Company shall be reimbursed from any recovery before payment of any other existing Claims, including any Claim by the Covered Person for general damages. The Company may collect from the proceeds of any settlement or judgment recovered by the Covered Person, or his or her legal representative, regardless of whether the Covered Person is fully compensated.

The Covered Person agrees to cooperate in protecting the interests of the Company. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person. The Covered Person's failure to cooperate with the Company may result in such Covered Person's termination under the Policy.

The Covered Person shall not settle any Claim, or release any person from liability, without

the written consent of the Company, if such release or settlement extinguishes or bars the Company's rights of reimbursement.

In the event the Company employs an attorney for the purpose of enforcing any part of this section against a Covered Person, based on the Covered Person's failure to cooperate with the Company, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorneys' fees.

In lieu of payment as indicated above, the Company, at its option, may choose to be subrogated to the Covered Person's rights to the extent of the benefits received under the Policy. The Company's subrogation right shall include the right to bring suit in the Covered Person's name. The Covered Person shall fully cooperate with the Company when the Company exercises its right of subrogation and the Covered Person shall not take any action or refuse to take any action which should prejudice the rights of the Company under this section.

2. Non-Duplication of Benefits

- a. **Workers' Compensation.** The Company shall not furnish benefits under the Policy to any Covered Person which duplicate benefits the Covered Person is entitled to under any Workers' Compensation law.

In the event of a dispute regarding the Covered Person's receipt of benefits under Workers' Compensation laws, the Company will provide the benefits described in the Policy until resolution of the dispute.

In the event the Company provides benefits which duplicate the benefits the Covered Person is entitled to under Workers' Compensation law, the Covered Person agrees to reimburse the Company, for all such benefits provided by the Company, immediately upon obtaining any monetary recovery. The Covered Person shall hold any sum collected as the result of a Workers' Compensation action in trust for the Company. Such sum shall equal the lesser of the amount of the recovery obtained by the Covered Person or the benefits furnished to the Covered Person by the Company on account of each incident.

The Covered Person agrees to cooperate in protecting the interests of the Company under this provision. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person.

- b. **Medicare Benefits.** The Covered Person shall furnish information to the Company upon request concerning eligibility for Medicare (Part A and/or Part B coverage). In those instances set forth in the "Medicare is Primary" section below, the Company shall not furnish benefits under the Policy which duplicate the benefits the Covered Person is entitled to as a Medicare beneficiary, regardless of whether or not the Covered Person actually enrolled in Medicare. Should the cost of medical or Hospital services exceed Medicare coverage, the Company benefits shall be provided over and above such

coverage.

If payment is made by the Company in duplication of the benefits available to the Covered Person as a Medicare beneficiary, as set forth in the "Medicare Is Primary" section below, the Company may seek reimbursement from the Insurance carrier, Provider, or Covered Person up to the amount of benefits which duplicate Medicare benefits.

- c. **The Company Is Primary.** In the following instances, the Company will provide benefits to Covered Persons with Medicare coverage, and Medicare will be responsible for payment only to the extent of services not covered under the Policy:
- 1) Aged employees: Insured Persons who are Actively At Work and are age 65 or older, or any Dependent age 65 or older.
 - 2) Disabled employees (large employer): Covered Persons eligible for Medicare as a result of a disability if Covered Persons are enrolled through an Employer that has [100] or more Full-Time Employees; and
 - 3) End-Stage Renal Disease (ESRD) Beneficiaries (Initial Period): The Covered Persons entitled to Medicare solely on the basis of ESRD for a maximum of 30 months, beginning the earlier of: a) the month in which the Covered Person initiates a regular course of renal dialysis; or b) the month in which an individual who receives a kidney transplant could become entitled to Medicare.
- d. **Medicare Is Primary.** In the following instances, the Company's coverage will be limited to the cost of Covered Services not covered by Medicare:
- 1) Covered Persons who meet the following definition of Medicare Retiree: a Covered Person who is: a) eligible for Medicare Part A and/or Part B (whether or not enrollment in Medicare actually occurs); b) eligible for retiree coverage provided by the Group Policyholder; and c) properly enrolled under the Policy.
 - 2) Small group employees: Covered Persons enrolled through an Employer with fewer than 20 Full-Time Employees.
 - 3) Disabled employee (small groups): Covered Persons eligible for Medicare as a result of disability, who are enrolled through an Employer with fewer than [100] Full-Time Employees.
 - 4) End-Stage Renal Disease (ESRD) Beneficiaries (Subsequent Period): Covered Persons entitled to Medicare as result of ESRD who do not meet the requirements of "The Company is Primary" section.
- e. **CHAMPUS Benefits.** The Covered Person shall furnish, upon request from the Company, information concerning any applicable benefits from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which the Covered Person may be entitled to receive. The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under CHAMPUS.
- If payment is made by the Company in duplication of the benefits available under CHAMPUS, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under CHAMPUS.
- f. **Automobile, Accident or Liability Coverage.** The Company shall not furnish benefits which duplicate benefits the Covered Person is entitled to under any automobile,

accident or liability coverage. The Covered Person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the Company of receipt of such available benefits. If payment is provided by the Company in duplication of the benefits under other automobile, accident or liability coverage, the Company may seek reimbursement for the duplicate benefits.

Should the cost of Covered Services exceed the benefits under any other liability coverage pursuant to this section, the Policy benefits will be provided over and above such liability coverage.

SECTION THREE

Covered Person Eligibility

- Who Is A Covered Person?
- Adding Dependents
- Late Enrollment
- Updating Your Enrollment Information
- Termination of Benefits
- Coverage Options Following Termination

This section describes how you become an Insured Person, as well as how you can add Dependents to your coverage. It will also answer other questions about eligibility, such as when Late Enrollment is permitted. In addition, you will learn ways you may be able to extend your coverage when it would otherwise terminate.

WHO IS A COVERED PERSON?

There are two kinds of Covered Persons: the Insured Person who enrolls in the Policy through his or her Employer and their eligible Dependents. The Employer, in turn, has signed a Policy with the Company.

The following Dependents are eligible to enroll in the Policy:

1. The Insured Person's Spouse who is not legally separated;
2. The unmarried biological children of the Insured Person or the Insured Person's Spouse (step-children) who are under age 21 (or as determined by the Employer);
3. Unmarried children who are legally adopted or placed for adoption with the Insured Person or the Insured Person's Spouse who are under age 21 (or as determined by the Employer);
4. The unmarried biological children of the Insured Person or the Insured Person's Spouse (step-children) who are age 21 or older but under age 25 (or as determined by the Employer) and who are full-time students at an accredited college or university;
5. Children for whom the Insured Person or the Insured Person's Spouse has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to The Company upon request; and
6. Children for whom the Insured Person or the Insured Person's Spouse is required to provide health insurance coverage pursuant to a qualified medical child support order assignment order, or medical support order, in this section.
7. Unmarried children meeting all of the following conditions:
 - a. totally and permanently disabled and unable to earn a living (proof of such disability must be submitted to the Company within 30 days of the date coverage would have ended due to the child's age);
 - b. dependent on the Insured Person for principal economic support; and
 - c. covered under the Policy on a day prior to the day coverage would have ended due to

the child's age.

At any time, the Company may require proof that a child continues to qualify as a Dependent. In addition to natural children, legally adopted children, and a child the Insured Person is seeking to adopt, the word "child" includes an Insured Person's stepchild if the child:

1. resides in the Insured Person's household; and
2. is dependent on the Insured Person for principal economic support.

The term Dependent does not include any person serving in the armed forces of any country.

If a husband and wife are both Insured Persons, their Dependents, if any, may be considered as Dependents of either the husband or wife, but not of both. A Covered Person may either be an Insured Person or a Dependent of an Insured Person, but not both at the same time.

ELIGIBILITY

The Company's eligibility requirements are:

Insured Person

A Person becomes eligible for the coverage provided by the Policy on the latest of the following dates:

1. the Policy Effective Date;
2. the effective date of coverage for the Employer; or
3. the date the Person completes the Waiting Period as a Full-Time Employee.

Dependent

Each Dependent of an Insured Person becomes eligible for Dependent Insurance provided by the Policy on the later of:

1. the date the Insured Person becomes eligible for personal insurance; and
2. the date the Insured Person first acquires the Dependent.

Eligible Dependents must enroll at the same time as the Insured Person or risk not being eligible to enroll until the Employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to the Company all applications, medical review questionnaires or other forms or statements that the Company may reasonably request.

Enrollment is the completion of a Company enrollment form (or a non-standard enrollment form approved by the Company) by the Insured Person on his or her own behalf or on the behalf of any eligible Dependent. Enrollment is conditional upon acceptance by the Company; the existence of a valid Employer Policy; and the timely payment of applicable health plan Premiums. The Company may in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

Your effective date of enrollment in the Policy will depend on when and how you enroll. These circumstances are explained below.

OPEN ENROLLMENT

Most Covered Persons enroll in the Policy during the Open Enrollment Period established by the Employer. This is the period of time established by the Employer when its eligible Employees and their eligible Dependents may enroll in the Employer's health benefit plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the Employer and the Company.

ADDING DEPENDENTS TO YOUR COVERAGE

The Insured Person's Spouse and eligible children may apply for coverage with the Company during the Employer's Open Enrollment Period. If you are declining enrollment for yourself or your dependents (including your Spouse) because of other health plan or insurance coverage, you may in the future be able to enroll yourself or your Dependents in the health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Dependents to enroll). Under the following circumstances, new Dependents may be added outside the Open Enrollment Period.

1. **Getting married.** When a new Spouse or child becomes an eligible Dependent as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.
2. **Having a baby.** Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Insured Person must submit a change request form to The Company prior to the expiration of the 30-day period for coverage to continue beyond the first 30 days of life.
3. **Adoption or Placement for Adoption.** Receive an adoptive placement from a recognized county or private agency, or adopted as documented by a health facility minor release form, a medical authorization form or a relinquishment form, granting you or your Spouse the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Insured Person's or Spouse's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
4. **Guardianship.** To enroll a Dependent child for whom the Insured Person has assumed legal guardianship, the Insured Person must submit a change request form to The Company along with a certified copy of a court order granting guardianship within 30 days of when the Insured Person assumed legal guardianship. Coverage will be retroactively effective to the date the Insured Person assumed legal guardianship.

5. Qualified Medical Child Support Order

A Covered Person (or a person otherwise eligible to enroll in the Company) may enroll a child who is eligible to enroll in the Policy upon presentation of a request by a district attorney, State Department of Health Services or a court order to provide medical support for such a dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a Covered Person may ask about obtaining dependent coverage as required by a court or administrative order, including a qualified medical child support order, by calling the Company's customer service department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the ID card, *Certificate* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or district attorney. Coverage will begin on the first of the month following receipt by the Company of an enrollment form with the court or administrative order attached.

CONTINUING COVERAGE FOR STUDENTS AND DISABLED DEPENDENTS

Certain Dependents who would otherwise lose coverage under the Policy due to their attainment of the Limiting Age established by the Employer may extend their coverage under the following circumstances:

Continuing Coverage for Student Dependents

An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by the Company) at an accredited school or college may continue as an Eligible Dependent through the Limiting Age established by the Employer for full-time students, if proof of such status is provided to the Company on a periodic basis.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents, who attain the Limiting Age established by the Employer, may continue enrollment in the Policy beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
2. The unmarried Dependent is chiefly dependent upon the Insured Person for support and maintenance; and
3. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to The Company by the Covered Person within 31 days of the onset of the disability, attainment of the Limiting Age or at the time of the Insured Person's initial enrollment in the Policy.

The Company may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

EFFECTIVE DATES

In addition to a Special Enrollment Period due to the addition of a new Spouse or child, there are certain circumstances when employees and their eligible Dependents may enroll outside of the Employer's Open Enrollment Period. These circumstances include:

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Dependents) declined in writing to enroll in the Company when they were first eligible because they had other health care coverage; and
2. The Company cannot produce a written declination statement from the Group Policyholder or eligible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible Dependents) was provided with and a signed acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with The Company during the initial enrollment period permits the plan to impose an exclusion of coverage under the health plan for a period of 12 months from the date of election of coverage under the Health Plan, unless the eligible Employee or Dependent can demonstrate that he or she meets the requirements for late enrollment.
3. The other health care coverage is no longer available due to:
 - i. The Employee or eligible Dependent has exhausted COBRA continuation coverage under another group health plan; or
 - ii. The termination of employment or reduction in work hours of a person through whom the Employee or eligible Dependent was covered; or
 - iii. The termination of the other health plan coverage; or
 - iv. The cessation of an Employer's contribution toward the Employee or eligible Dependent coverage; or
 - v. The death, divorce or legal separation of a person through whom the Employee or eligible Dependent was covered.
4. The Court has ordered health care coverage be provided for a Spouse or minor child.

If the Employee or an eligible Dependent meets these conditions, the employee must request enrollment with the Company no later than 30 days following the termination of the other health plan coverage. The Company may require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by the Company of a completed request for enrollment.

Late Enrollment

In the event a Person or Dependent who is eligible for coverage under the Policy declines enrollment for such coverage during an Open Enrollment Period or within 31 days of becoming eligible, and subsequently requests enrollment, Personal Insurance or Dependent Insurance will become effective on the first day of the Insurance Month following the end of the next Open Enrollment Period after the date on which the Person enrolled, unless the Person or Dependent is eligible for Special Enrollment Period.

Exception to Effective Date

If an Insured Person's coverage terminates due to an approved leave of absence or military leave, the Company will waive any Waiting Period upon the Person's return; provided:

- a. the Person returns within six months after the leave of absence or military service begins; and
- b. the Person applies or is enrolled within 31 days after resuming Active Work.

UPDATING YOUR ENROLLMENT INFORMATION

Please notify your Employer of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Dependent.

ENDING COVERAGE (TERMINATION OF BENEFITS)

Usually, your enrollment in the Policy terminates when the Insured Person or enrolled Dependent is no longer eligible for coverage under the Employer's health benefit plan. In most instances, your Employer determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this health benefit plan is subject to the terms and conditions of the Employer's Policy with the Company.

When the Policy between the Employer and the Company is terminated, all Covered Persons under the Policy become ineligible for coverage on the date of termination. If the Policy is terminated by the Company for non-payment of Premiums, coverage for all Covered Persons under the Policy will be terminated effective the last day for which Premiums were received. According to the terms of the Policy, the Group Policyholder is responsible for notifying you if and when the Policy is terminated for any reason, including the non-payment of Premiums. The Company is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

In addition to terminating the Policy, the Company may terminate a Covered Person's coverage if he or she no longer meets the eligibility requirements established by the Group Policyholder and/or the Company.

Termination for Good Cause:

The Company has the right to terminate your coverage under this Policy in the following situations:

1. the Insured Person's Personal Insurance terminates;
2. Dependent Insurance is discontinued under the Policy;
3. the Insured Person ceases to be eligible for Dependent Insurance;
4. the Insured Person requests that the Dependent Insurance be terminated; or

5. the last day of the premium paying period for which the Insured Person has made any required contribution toward the cost of the Dependent Insurance.
- Dependent Insurance on a Dependent will cease on the date such person ceases to be a Dependent as defined in the Policy. However, coverage for a Dependent child enrolled hereunder by a court or administrative order to provide health insurance coverage for the child will not terminate except because:
 1. the Small Employer has eliminated family health insurance coverage for all its employees; or
 2. the Company or Employer receives satisfactory written evidence that:
 - a. the court order or administrative order is no longer in effect or is legally terminated; or
 - b. through another insurer, the child is or will be enrolled in comparable health insurance that will take effect not later than the effective date of the child's disenrollment.
 - Fraud or Misrepresentation. Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities services provided under the Policy (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date the Company mails the notice of termination, unless the Company has specified a later date in that notice.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the Company conversion plan (discussed below) or COBRA plan and lose the right to re-enroll in the Company's health plan in the future. Under no circumstances will a Covered Person be terminated due to health status or the need for health care services. If a Covered Person is Totally Disabled when the Group Policyholder's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability").

NOTE: If a Policy is terminated by the Company, reinstatement with the Company is subject to all terms and conditions of the Policy between the Company and the Employer.

Ending Coverage: Special Circumstances for Enrolled Dependents: Enrolled Dependents terminate on the same date of termination as the Insured Person. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered unless a qualified court order is presented to the Company requesting eligibility not end. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the Employer and do not qualify for extended coverage as a student Dependent or as a disabled dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a qualified student reaches the Limiting Age.

TOTAL DISABILITY

If a Covered Person is Totally Disabled at the time his or her coverage ends, coverage for such Total Disability will be extended for the Injury or Sickness causing the Total Disability. This extension will end on the earliest of the following:

1. the date such Covered Person is no longer Totally Disabled;
2. 12 months from the date his or her coverage under the Policy would otherwise have terminated; or
3. the date such Covered Person acquires coverage under a replacement health plan that provides similar benefits, but only if such plan covers the Injury or Sickness causing the Total Disability without limitation due to the Injury or Sickness having begun prior to the effective date of the replacement health coverage.

COVERAGE OPTIONS FOLLOWING TERMINATION (INDIVIDUAL CONTINUATION OF BENEFITS)

If your coverage through this Certificate ends, you and your enrolled Dependents may be eligible for additional continuation coverage:

FEDERAL COBRA CONTINUATION COVERAGE

If the Insured Person's Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), you may be entitled to temporarily extend your coverage under the health plan at group rates, plus an administration fee, in certain instances where your coverage under the health plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer regarding the availability and duration of COBRA continuation coverage.

If you are an Insured Person covered by this health plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because the termination of your employment (for reasons other than gross misconduct on your part) or the reduction of hours of employment to less than the number of hours required for eligibility.

If you are the Spouse of a Insured Person covered by this health plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this health plan for any of the following four reasons:

1. The death of your Spouse;
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment to less than the number of hours required for eligibility;
3. Divorce or legal separation from your Spouse; or
4. Your Spouse becomes entitled to Medicare

In the case of a Dependent child of a Insured Person enrolled in this health plan, he or she has the

right to continuation coverage if group health coverage under this health plan is lost for any of the following five reasons:

1. The death of the Insured Person;
2. A termination of the Insured Person's employment (for reasons other than gross misconduct) or reduction in the Insured Person's hours of employment to less than the number of hours required for eligibility;
3. The Insured Person's divorce or legal separation;
4. The Insured Person becomes entitled to Medicare; or
5. The Dependent child ceases to be a Dependent eligible for coverage under this health plan.

Under COBRA, the Insured Person or enrolled Dependent has the responsibility to inform the Employer (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing dependent status under the Health Plan within 60 days of the date of the event. Your Employer has the responsibility to notify its COBRA administrator of the Insured Person's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses and dependent children if your Employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the COBRA administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this health plan will end.

If you choose continuation coverage, your Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or Dependents. COBRA permits you to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to 29 months if you are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. Please contact your Employer or its COBRA administrator for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the Insured Person during a period of COBRA continuation coverage will be eligible to enroll as a COBRA qualified beneficiary. These COBRA qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Employer or COBRA administrator of the birth or adoption.

However, under COBRA, the continuation coverage may be cut short for *any* of the following five reasons:

1. Your Employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Under the law, you may have to pay all of the premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102% of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150% of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer or COBRA administrator. Your Employer or COBRA administrator is responsible for the timely submission of Premium to the Company. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries will be allowed to enroll in a Company or Designated Medical Conversion Carrier's individual conversion health plan.

If you have any questions about COBRA, please contact your Employer.

CALIFORNIA CONTINUATION COVERAGE AFTER COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 % of the premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by the Company at the time your COBRA benefits run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

California Continuation Coverage Enrollment and Premium Information After COBRA

You must notify the Company within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage; or within 60 days from the date you received notice from the Company. The 60-day period will be counted from whichever event occurs last. Your request must be in writing and delivered to the Company by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by the Company. You must pay your initial premiums to the

Company within 45 days from the date the Company mails your enrollment package after you notified the Company of your intent to enroll. Your first premium must equal the full amount billed by the Company. Your failure to submit the correct premium amount billed to you within the 45-day period, which includes checks returned to the Company by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll on or after January 1, 2003. Your qualifying event occurs on the first day in which you were initially no longer eligible for your group health plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. The end of the period for which premium payments were made, if you cease or fail to make timely premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for the Company's coverage; or
5. The contract for health care services between your employer and the Company is terminated; or
6. You become entitled for Medicare. Note: If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate 36 months after your qualifying event, but only if you send the Social Security Administration notice to your former Employer or COBRA Administrator within 30 days of the determination; or
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with the Company's coverage, you may continue the remaining balance of your unused coverage with the Company, but only if you enroll with and pay premiums to the Company within 30 days of receiving notice of your termination from the prior group health plan.

If the contract between your former employer and the Company terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

CALIFORNIA CONTINUATION COVERAGE AFTER COBRA FOR CERTAIN FORMER EMPLOYEES AND THEIR SPOUSES

California law also provides that certain former employees and their dependent Spouses (including a Spouse who is divorced from the employee and/or a Spouse who was married to the employee at the time of that employee's death) may be eligible to continue group coverage beyond the date their

COBRA and California Continuation COBRA coverage is scheduled to end. Prior to you reaching your combined benefit of 36 months, the Company will offer the extended coverage to employees and dependent Spouses of employees that are subject to the existing COBRA and California Continuation COBRA laws and to the former employees' dependent Spouses, including divorced or widowed Spouses as described above.

This coverage is subject to the following conditions:

1. The former employee worked for the employer for the prior five years and was 60 years of age or older on the date his/her employment ended and,
2. The former employee was eligible for and elected COBRA for himself and his dependent Spouse or,
3. A former Spouse (i.e., a divorced or widowed Spouse as described above) is also eligible for continuation of group coverage after they have used all of their available COBRA benefit coverage. The former Spouse must elect such coverage by notifying the Company in writing within 30 calendar days prior to the date that the initial COBRA benefits are scheduled to end. A former spouse or surviving spouse may continue Continuation COBRA for up to five continuous years upon the date the full 36 months of COBRA benefits have been used, regardless of the age or length of employment of the Subscriber.

If elected, this coverage will begin after your 36th month of COBRA coverage and will be administered under the same terms and conditions as if COBRA had remained in force.

Premiums for this coverage will be 213% of the current applicable group rate. Your premium may be increased each time your former Employer Group's benefit package renews or changes. Payment is due at the time the Group Policyholder's payment is due.

For California Continuation Coverage, the Company will bill you directly once we have received your election form. You are responsible for paying the Health Plan Premium directly to the Company on a monthly basis and it must be delivered by first class mail or other reliable means. The first month's California Continuation COBRA Health Plan Premium payment is due within 45 days of the date that you submit the election form to the Company. This payment must be sufficient to pay all premiums due from the first month after the qualifying event through the current month. Failure to submit the correct premium amount will disqualify you from receiving California Continuation coverage. Please note you will not be enrolled in California Continuation COBRA until the Company receives both your election form and your first premium payment.

Thereafter, California Continuation Coverage premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your premium by the first of the month in which your premium payment should apply, the Company will send you a 15-day notice reminding you that your premium is overdue. If you still do not pay your premium, the Company will terminate you back to the month in which your premiums were paid. A termination notice will be sent to you at this time. If you are terminated for failing to make timely premium, you are not eligible for the Company's conversion plan.

Termination of Continuation Coverage After COBRA for Certain Employees and Their Spouses as Described in the Above Paragraph

This coverage will end automatically on the earlier of:

1. The date the former employee, Spouse, or former Spouse reaches 65;

2. The date in which the Group Policyholder terminates its Policy contract with the Company and ceases to provide coverage for any active employees through the Company;
3. The date the former employee, Spouse, or former Spouse is covered by another health plan;
4. The date the former employee, Spouse or former Spouse becomes eligible for Medicare;
5. For a Spouse or former Spouse, five years from the date the Spouse's COBRA coverage would end;
6. The date the former employee, Spouse or former Spouse fails to pay timely premium as billed by the Company, which includes failure to pay after receipt of the 15 day notice of overdue premium.

For a spouse or former spouse that has used the available California continuation coverage period of 5 years, qualified beneficiaries may be allowed to enroll in an individual conversion Health Plan, unless you are eligible for Medicare. Other exclusions may apply. Please see the explanation under "Extending Your Coverage: Converting to an Individual Plan".

EXTENDING YOUR COVERAGE: CONVERTING TO AN INDIVIDUAL CONVERSION PLAN

If you have been enrolled in this health plan for three or more consecutive months, you and your enrolled Dependents may apply for the individual conversion plan issued by the Company or Designated Medical Conversion Carrier. The Employer is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of the termination of your group coverage.

An application for the conversion plan must be received by the Company or Designated Medical Conversion Carrier within 31 days of the date of termination of your group coverage. However, if the Employer terminates its Policy with the Company or replaces the Company group coverage with another carrier, transfer to the individual conversion health plan is not permitted. You also will not be permitted to transfer to the individual conversion health plan under any of the following circumstances:

1. You failed to pay any amounts due to the health plan;
2. You were terminated by the health plan for good cause or for fraud or misrepresentation as described in the section "Termination for Good Cause";
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the health plan;
4. You are covered or are eligible for Medicare;
5. You are covered or are eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; or
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion plan health plan are different from those in your group plan.

An individual conversion health plan is also available to:

1. Dependents, if the Insured Person dies;

2. Dependents who marry or exceed the maximum age for dependent coverage under the group plan;
3. Dependents, if the Insured Person enters military service;
4. Spouse of the Insured Person, if their marriage has terminated.

Written applications for all conversions must be received by the Company or the Designated Medical Conversion Carrier within 30 days of the loss of group coverage. For more details, please contact our customer service department.

CERTIFICATE OF CREDITABLE COVERAGE

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a certificate of Creditable Coverage will be provided to the Insured Person by the Group Policyholder when the Insured Person or a Dependent ceases to be eligible for benefits under the Group Policyholder's health benefit plan. A certificate of Creditable Coverage may be used to reduce or eliminate a preexisting condition exclusion period imposed by a subsequent health plan. Creditable Coverage information for Dependents will be included on the Insured Person's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Insured Person's. Please contact the Company's customer service department if you need a duplicate certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your certificate of Creditable Coverage.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

Continuation of benefits under USERRA. Continuation coverage under this health plan may be available to you through your Employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Covered Persons regularly enrolled in this health plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 18-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. Your Employer will provide written notice to you for USERRA continuation coverage.

The Health Plan Premium for USERRA continuation of benefits is the same as the health plan Premium for other Covered Persons enrolled through your Employer plus a 2% additional surcharge or administrative fee, not to exceed 102% of your Employer's active group premium. Your Employer is responsible for billing and collecting health plan Premiums from you or your Dependents and will forward your health plan Premiums to the Company along with your Employer's health plan Premiums otherwise due under this Agreement. Additionally, your Employer is responsible to maintain accurate records regarding USERRA continuation Covered Person health plan Premium, qualifying events, terminating events and any other information that may be necessary for the Company to administer this continuation benefit.

SECTION FOUR

Health Care Decisions

- How The Company Makes Important Decisions
- What to Do If the Covered Person Has a Problem or Grievance
- Appealing a Health Care Decision
- Quality of Care Review
- The Appeals Process
- Independent Medical Review
- Claims Against A Participating Provider

This section explains how The Company authorizes or makes changes to a Covered Person's health care services, how the Company evaluates new health care technologies and how the Company reaches decisions about Your coverage.

How The Company Makes Important Health Care Decisions

AUTHORIZATION, MODIFICATION AND DENIAL OF HEALTH CARE SERVICES

The Company uses processes to review, approve, modify or deny, based on Medical Necessity, requests by Providers or Covered Persons for authorization of the Covered health care services.

The Company may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by Providers of health care services for Covered Persons. The criteria used to modify or deny requested health care services will be provided free of charge to the Provider, the Covered Person and the public upon request.

Decisions to deny or modify requests for authorization of health care services for a Covered Person, based on Medical Necessity, are made only by licensed physicians or other appropriately licensed health care professionals.

The Covered Person agrees that their Provider will be their "authorized representative" (pursuant to ERISA) regarding receipt of approvals of requests for health care services for purposes of medical management.

The Company makes these decisions within the following timeframes, as required by state law: Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Covered Person's condition, not to exceed five business days from The Company's receipt of the information reasonably necessary and requested to make the decision.

If the Covered Person's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Covered Person's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Covered Person's condition, not to exceed

72 hours after The Company's receipt of the information reasonably necessary and requested by The Company to make the determination (an "Urgent Request").

If the decision cannot be made within these timeframes because (I) The Company is not in receipt of all of the information reasonably necessary and requested or (II) The Company requires consultation by an expert reviewer, The Company will notify the Provider and the Covered Person, in writing, upon the earlier of the expiration of the required timeframes above or as soon as the plan becomes aware that it will not be able to meet the required timeframes.

The notification will specify the information requested but not received, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by The Company, The Company shall approve, modify or deny the request for authorization within the timeframes specified above as applicable.

The Company will notify requesting Providers of decisions to approve, modify, or deny requests for authorization of health care services for Covered Persons within 1 business day of the decision. Covered Persons are notified of decisions to deny, delay or modify requested health care services, in writing, within two business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with the Company. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Covered Person. The Company's Appeals Process is outlined below.

If the Covered Person requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above the Company will approve, modify or deny the request as soon as possible, taking into account the Covered Person's medical condition, and will notify the Covered Person of the decision within 24 hours of the request, provided the Covered Person makes the request to the Company at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, the Company will treat the request as a new request for a Covered Service and will follow the time frame for non-urgent requests as discussed above.

If the Covered Person would like a copy of the Company's policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, or any additional information about the utilization management process, the Covered Person should contact the Company Customer Service Department at the telephone number listed on the back of their ID Card.

ASSESSMENT OF NEW TECHNOLOGIES

The Company regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective. The Technology Assessment and Guideline Committee, which consists of The Company's Medical Directors, Providers, pharmacists and specialists, conducts careful reviews of case studies, clinical literature, and opinions of review organizations, such as *ECRI* (formerly the Emergency Care Research Institute), the Health Technology Assessment Information Service, the HAYES New Technology Summaries, the Agency for Health Care Policy and

Research, Medicare, and Federal Drug Administration decisions.

UTILIZATION CRITERIA

When a Provider or Covered Person requests Pre-Authorization of a procedure/service requiring Pre-Authorization, an appropriately qualified licensed health professional reviews the request. The licensed professional applies the applicable criteria, including, but not limited to:

- Nationally published criteria for utilization management.
- HCIA-Sachs Length of Stay® Guidelines (average length of Hospital stays by medical or surgical diagnoses)
- Technology Assessment Guidelines ("TAG") and Benefit Interpretation Policies ("BIP").

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Company Medical Director.

Denial, delay or modification of health care services based on Medical Necessity will be made by a licensed Physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for administrative reasons that include, but are not limited to, the fact that the patient is not a Covered Person or that the service being requested is not a benefit provided by the Policy.

Pre-Authorization determinations are made once the Company's Medical Director or designee receives all reasonably necessary medical information. The Company makes timely and appropriate initial determinations based on the nature of the Covered Person's medical condition and in compliance with state and federal requirements.

WHAT TO DO IF A COVERED PERSON HAS A PROBLEM OR GRIEVANCE

A Covered Person and the Company may not always agree that a Claim or request for services had been reviewed properly. When this happens, the Covered Person's first step should be to call the Company's Customer Service Department. The Company's Customer Service Department coordinator will assist the Covered Person and attempt to find a solution to the Covered Person's problem or grievance.

If the Covered Person feels that his/her problem or grievance requires additional action, the Covered Person may also request a formal Appeal. To learn more about this, read the following section: "Appealing a Health Care Decision."

APPEALING A HEALTH CARE DECISION

The Company's appeals and quality of care review procedures are designed to deliver a timely response and resolution to a Covered Person's problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance. The Covered Person may submit a formal appeal within 1 year of the receipt of an initial

determination through our Appeals Department. To initiate an appeal or quality of care review, call the Company's Customer Service Department or write the Appeals Department at the address below to receive an appeals or quality of care packet:

PacificCare Health Plan Administrators
Appeals Department
PO Box 400046
San Antonio, Texas 78229
1-866-316-9776

This written request will initiate the following Appeals Process, except in the case of "Urgent Requests" as discussed below. A Covered Person, or a representative appointed by a Covered Person including an Attorney, may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

The Company will review your appeal and if the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

QUALITY OF CARE REVIEW

All quality of care complaints requiring clinical review are reviewed by the Company. Complaints affecting your current condition are reviewed immediately. The Company conducts this review by investigating the complaint and consulting with your treating Providers. We also review medical records as necessary, and you may need to sign an authorization to release your medical records.

We will notify you in writing regarding your quality of care review within 30 days of receipt of your complaint. The results of the quality of care review are confidential and protected from legal discovery in accordance with State law. Please refer to the "Urgent Requests" section below for Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function.

If a Covered Person has asserted a Claim for benefits or reimbursement as part of a quality of care complaint the Claims for benefits or reimbursement will be reviewed through the Appeals Process described below.

Case Management Program

The Company has licensed registered nurses who, in collaboration with the Covered Person, the Covered Person's family and the Covered Person's Provider help arrange care for Covered Persons experiencing a major illness or recurring hospitalizations. Case Management is a collaborative

process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources.

THE APPEALS PROCESS

The Company will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination not later than 30 days of The Company's receipt of the appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the Certificate that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this Certificate captioned "Quality of Care Review."

URGENT REQUESTS

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to The Company's clinical review personnel. If your case does not meet the criteria for an Urgent Request, it will be reviewed under the appeal process. If your appeal requires urgent review, The Company will immediately inform you in writing of your review status.

BINDING ARBITRATION

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between the Covered Person (including any heirs or assigns) and the Company, or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare"); shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. The Covered Person and PacifiCare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Covered Person lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator.

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In cases of extreme hardship, PacifiCare may assume all or part of the Covered Person's share of the fees and expenses of JAMS and the arbitrator, provided the Covered Person submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

BY ENROLLING WITH THE COMPANY BOTH THE COVERED PERSON (INCLUDING ANY HEIRS OR ASSIGNS) AND THE COMPANY AGREE TO WAIVE THE CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS CERTIFICATE OF COVERAGE.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

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A Company medical director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in "Cancer Clinical Trials" under Section One: Your Medical Benefits. If you have a Terminal illness as defined below, you may request that The Company review the denial within 30 days of receiving your request. For purposes of this paragraph, Terminal illness means an incurable or irreversible condition that has a high probability of causing death within one year or less. The review will be held within five days if the treating Physician determines, in consultation with the Company Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

INDEPENDENT MEDICAL REVIEW

IF YOU BELIEVE THAT A HEALTH CARE SERVICE IMPROPERLY DENIED, MODIFIED OR DELAYED PARTICIPATING PROVIDERS, YOU MAY REQUEST ("IMR") OF THE DECISION. IMR IS AVAILABLE FOR DENIALS, DELAYS OR MODIFICATIONS OF HEALTH CARE SERVICES REQUESTED BY YOU OR YOUR PROVIDER BASED ON A FINDING THAT THE REQUESTED SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL OR IS NOT MEDICALLY NECESSARY. YOUR CASE ALSO MUST MEET THE STATUTORY ELIGIBILITY CRITERIA AND PROCEDURAL REQUIREMENTS DISCUSSED BELOW. IF YOUR COMPLAINT OR APPEAL PERTAINS TO A DISPUTED HEALTH CARE SERVICE SUBJECT TO INDEPENDENT MEDICAL REVIEW (AS DISCUSSED BELOW), YOU SHOULD FILE YOUR COMPLAINT OR APPEAL WITHIN 180 DAYS OF RECEIVING A DENIAL NOTICE

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ELIGIBILITY FOR INDEPENDENT MEDICAL REVIEW

Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of the Company's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Insurance Code Section 10145.3. Life-Threatening means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Physician certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
 - Standard therapies have not been effective in improving your condition, or
 - Standard therapies would not be medically appropriate for you, or
 - There is no more beneficial standard therapy covered By the Company than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.
2. Either (a) your Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Physician in certifying his or her recommendation; or (b) you or your Non-Participating Provider -- who is a licensed, board-certified or board-eligible Physician qualified to practice in the specialty appropriate to treating your condition -- has requested a therapy that, based on two documents of medical and scientific evidence identified in California Insurance Code Section 10145.3(d), is likely to

be more beneficial than any available standard therapy. To satisfy this requirement, the Physician certification must include a statement detailing the evidence relied upon by the Physician in certifying his or her recommendation. (PLEASE NOTE that the Company is not responsible for the payment of services rendered by Non-Participating Providers who are not otherwise covered under your benefits).

3. A Company Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for the Company's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and the Company denies your request for Experimental or Investigational therapy, the Company will send a written notice of the denial within five business days of the decision. The notice will advise you of your right to request IMR, and include a Physician certification form and an application form with a pre-addressed envelope to be used to request IMR from the Department of Insurance (the "Department").

Disputed Health Care Services

You may also request IMR of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your health plan that has been denied, modified or delayed by the Company or one of its Participating Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (NOTE: Disputed Health Care Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

You are eligible to submit an application to the Department for IMR of a Disputed Health Care Service if you meet all of the following criteria:

1. (a) Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or (c) you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service has been denied, modified or delayed by the Company or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed an appeal with the Company regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 days (or three days in the case of an urgent appeal requiring expedited review). (NOTE: If there is an imminent and serious threat to your health the Department may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the Department determines that an earlier review is necessary in extraordinary and compelling cases if the Department finds that you have acted reasonably.)

You may apply to the Department for IMR of a Disputed Health Care Service within six months of any of the events or periods described above, or longer if the Department determines that the circumstances of your case warrant an IMR review. The Company will provide you an IMR application form with any grievance disposition letter that denies, modifies or delays health care services based in whole or in part due to a finding that the service is not Medically Necessary. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Company regarding the Disputed Health Care Service. The IMR process is in addition to any other procedures or remedies that may be available to you.

INDEPENDENT MEDICAL REVIEW PROCEDURES

Applying for Independent Medical Review

In the case of Experimental or Investigational coverage decisions, if you have a Life-Threatening or Seriously Debilitating condition, the Company will include an application for IMR in its notice to you that the requested service has been denied and include a Physician certification form with a pre-addressed envelope to the Department. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the Department by your Physician. Either you or your Physician can provide the letter from the Company or its Participating Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service is not Medically Necessary, the Company will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or emergency basis was Medically Necessary, and any other information you received from or gave to the Company or its Participating Providers that you believe is relevant in support of your position that the Disputed Health Care Service was Medically Necessary.

Completed applications for IMR should be submitted to the Department. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the Department that was not previously provided to the Company, you may include this information with the application for IMR. The Department fax number is 1-213-897-5891. You may also reach the Department by calling 1-800-927-4357.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the Department will review your request and notify you whether your case has been accepted. If your case is eligible for IMR, the dispute will be submitted to an Independent medical review organization (IRO) contracted with the Department for review by one or more expert reviewers, independent of the Company, who will make an Independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor the Company will control the choice of expert reviewers.

The Company must provide the following documents to the IRO within three business days of receiving notice from the Department that you have successfully applied for an IMR:

1. The relevant medical records in the possession of the Company or its Participating Providers;
2. All information provided to you by the Company and any of its Participating Providers concerning PacifiCare and Provider decisions regarding your condition and care (including a copy of the Company's denial notice sent to you);
3. Any materials that you or your Provider submitted to the Company and its Participating Providers in support of the request for the health care services;
4. Any other relevant documents or information used by the Company or its Participating Providers in determining whether the health care service should have been provided and any statement by the Company or its Participating Providers explaining the reasons for the decision. The Company shall provide copies of these documents to you and your Provider unless any information in them is found by the Department to be privileged.

If there is an imminent and serious threat to your health, the Company will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IRO, the Company will promptly issue you a notification that includes an annotated list of the documents submitted and offer you the opportunity to request copies of those documents from the Company.

If there is any information or evidence you or your Provider wish to submit to the Department in support of IMR that was not previously provided to the Company, you may include this information with your application to the Department. Also as required, you or your Provider must provide to the Department or the IRO copies of any relevant medical records, and any newly developed or discovered relevant medical records after the initial documents are provided, and respond to any requests for additional medical records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The Independent review panel will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical, within 30 days of receiving your request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven days of the request for expedited review. The review period can be extended up to three days for a delay in providing required documents at the request of the expert.
- If the health care service has not been provided and your Provider or the Department certifies in writing that an imminent and serious threat to your health may exist, including, but not limited to; serious pain, the potential loss of life, limb or major bodily function or the

immediate and serious deterioration of your health. In this instance, any analyses and recommendations of the experts must be expedited and rendered within three days of the receipt of your application and supporting information.

- If approved by the Department, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the Department, the Company, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by the Company, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation. In the case of a review of a Disputed Health Care Services denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewer's relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the health care service should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service, the Company will not be required to provide the service.

When a Decision is Made

The Department will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on the Company. The Company will promptly implement the decision when received from the Department. In the case of an IRO determination requiring reimbursement for services already rendered, the Company will reimburse either you or your Provider – whichever applies – within five working days. In the case of services not yet rendered to you, the Company will authorize the services within five working days of receiving the written decision from the Department, or sooner if appropriate for the nature of your medical condition and will inform you and your Physician of the authorization.

The Company will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Services outside of the Company's Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The Department finds your decision to secure services outside of the Company's Participating Provider network prior to completing the Company's grievance process or seeking IMR was reasonable under the circumstances; and
- The Department finds that the Disputed Health Care Services were a covered benefit under the Policy.

Health care services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under your health plan.

For more information regarding the IMR process, or to request an application, please call the Company's Customer Service Department.

CLAIMS AGAINST PARTICIPATING PROVIDERS

Claims against a Participating Provider -- other than claims for benefits under your coverage -- are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Participating Provider for claims not involving benefits, the Company agrees to make available the Covered Person appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The grievance will not be subject to binding arbitration except upon agreement between the parties. Should the parties fail to resolve the grievance, you or the Participating Provider may seek any appropriate legal action deemed necessary. Covered Person claims against the Company will be handled as discussed above under "Appealing a Health Care Decision."

STATEMENT OF ERISA RIGHTS

Contact your Company Benefit Administrator to learn whether your plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). If you participate in an ERISA employee welfare benefit plan, ERISA provides you with certain rights and protections.

1. All benefit determination, or claim, procedures are described for you in your summary plan description.
2. If you receive an adverse benefit determination, a determination notice will be forwarded to you, electronically or in writing, within a reasonable time not to exceed ninety (90) days of the date the claim is submitted.
3. You may appeal any adverse benefit determination. ERISA provides you with at least one hundred and eighty (180) days from the day you receive notice of an adverse benefit determination to appeal it. You will be provided an opportunity to submit relevant information in support of your appeal.
4. ERISA provides for up to two (2) mandatory appeal levels for any adverse determination. You have a right to bring a civil action on any adverse determination that you believe, after participating in the mandatory appeal process, was incorrectly made under your plan.
5. ERISA provides that, in connection with any appeal of an adverse benefit determination, you have the right to request access to and receive a free copy of any and all documents, records, and other information, as follows:
 - a. Relied on in making your benefit determination;
 - b. Submitted, considered, or generated in the course of making your benefit determination;
 - c. Which demonstrates compliance with administrative safeguards concerning consistent application of the plan document among similar claims, and
 - d. Any plan policy statement or guidance regarding your diagnosis.
6. ERISA provides that most benefit appeal determination notices will be forwarded to you, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.
7. Your plan or your state insurance code provides you with the right to a voluntary Independent External Review. This review is conducted by an Independent Review Organization with no financial, personal or professional connection to your plan and no prior knowledge of your claim's facts. Your plan will provide the Independent Review Organization any and all information it relied on in making the adverse benefit determination. You may provide any additional information you believe is relevant to the claim determination.
8. Your participation in a voluntary appeal level does not effect your legal review rights, or any rights you have under your plan. Any statute of limitations will be tolled during the time you participate in a voluntary review level.

9. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

SECTION FIVE

Definitions

The Company is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Certificate, as well as the Schedule of Benefits.

Accident - an acute injury that happens suddenly, unexpectedly and without design of the person injured. An accident does not include any activity, which ordinarily would not injure a person in good health.

Actively At Work or Active Work - a Person's full-time performance of all customary duties of the Person's occupation at the Employer's place of business, or at another business location to which the Employer requires the Person to travel.

Administrator - an appropriately licensed organization with whom the Company has contracted to perform administration services. Applicable Administrators are identified under the Administrators section of the Certificate.

Calendar Year - January 1, 12:00 AM to December 31, 11:59 PM of the same year.

Calendar Year Deductible - the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each Calendar Year before benefits are payable under the Policy. Covered Expense that a Covered Person has to pay due to any additional Deductibles or any Copayments will not be applied toward satisfying the Calendar Year Deductible.

Claim - Notification in a form acceptable to the Company that a Covered Service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such Covered Service as required by the Company.

Claim Determination Period - A Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

COBRA - Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate the conditions and manner in which an Employer must offer continuation of group health insurance to Covered Persons whose coverage would otherwise terminate under the terms of the Policy.

Company Authorized Transplant Facility - A of transplant Facility that is:

- Licensed in the State in which it operates;
- Certified by Medicare as a transplant Facility for a specific organ transplant; and
- Is authorized by the Company to perform transplant services under the Policy provisions.

Note: Regional Organ Procurement Agency is defined as an organization designated by the federal government and responsible for procurement of organs for transplantation

Complementary and Alternative Medicine - Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies (schools of thought), approaches and therapies that Conventional Medicine does not commonly use, accept, study or

make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in Hospitals. These types of therapies used alone are often referred to as "alternative." When used in combination with other alternative therapies, or in addition to conventional therapies, these therapies are often referred to as "complementary."

Coinsurance - that portion of the Covered Expense, which is not payable as a benefit due to the Percentage Payable being less than 100%. Coinsurance does not include any Deductibles or Copayments. Coinsurance does not include any amounts payable by the Covered Person because Preauthorization was not obtained. Coinsurance does not include any amounts payable by the Covered Person which are not considered as Covered Expense under the Policy.

Coinsurance Maximum - means the Coinsurance Maximum shown on the Schedule of Benefits. When a Covered Person has paid an amount of Coinsurance during the Calendar Year equal to one of the Coinsurance Maximums, then the Percentage Payable will be 100% for all additional Covered Expenses the Covered Person incurs during the rest of that Calendar Year for the type of Provider for which the Coinsurance Maximum has been reached. Coinsurance amounts paid for Covered Services incurred at Participating Providers do not apply toward the Coinsurance Maximum for Non-Participating Providers. Coinsurance amounts paid for Covered Services incurred at Non-Participating Providers do not apply toward the Coinsurance Maximum for Participating Providers. Coinsurance for certain types of Covered Expense does not apply toward the Coinsurance Maximum, and the Percentage Payable for certain types of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum. Please refer to your Schedule of Benefits to determine applicability to Your plan.

Copayment - Portion of Covered Expense which is the responsibility of the Covered Person and which are shown as Copayments on the Schedule of Benefits. Copayments do not apply towards the Deductible and do not accrue toward the Coinsurance Maximum. Copayments will continue to be required after the Coinsurance Maximum has been reached.

Corrective Appliances - Corrective Appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Covered Person (this definition does not include foot orthotics).

Covered Expense - An expense that:

1. is incurred for a Covered Service provided to a Covered Person; and
2. does not exceed the smallest of any Policy maximum that may apply to the covered expense; and
3. for Participating Providers, does not exceed any applicable negotiated fees; and
4. for Non-Participating Providers, does not exceed the lesser of billed charges, or Usual and Customary Charges, or the Limited Fee Schedule maximum that may apply to the Covered Service.

Covered Person - The Insured Person and/or the Dependent(s) of the Insured Person who are insured under the Policy.

Covered Service - a service or supply that is included in the Comprehensive Major Medical Coverage section of the Certificate and is:

1. prescribed by a Provider; and
2. Medically Necessary for the treatment of an Injury or Sickness.

Creditable Coverage - Coverage under any of the following:

1. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employer Retirement Income Security Act of 1974;
2. a group health benefit plan provided by a health insurance carrier or health maintenance organization;
3. an individual health insurance policy or evidence of coverage;
4. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
5. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
6. Chapter 55 of Title 10, United States Code;
7. a medical care program of the Indian Health Service or of a tribal organization;
8. a state or political subdivision health benefits risk pool;
9. a health plan offered under Chapter 89 of Title 5, United States Code;
10. a public health plan (as defined in federal regulations); or
11. a health benefit plan under Section 5 (e) of the Peace Corps Act.

Creditable Coverage does not include coverage consisting solely of the following:

1. coverage only for accidents, or disability income insurance, or any combination thereof;
2. liability insurance, or coverage issued as a supplement to liability insurance;
3. workers' compensation or similar insurance;
4. automobile medical payment insurance;
5. credit-only insurance;
6. coverage for on-site medical clinics; or
7. other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable Coverage does not include any of the following, if offered separately:

1. limited scope dental or vision benefits;
2. long term care, nursing home care, home health care, community-based care, or any combination thereof;
3. Medicare Supplemental health insurance;
4. coverage supplemental to coverage under Chapter 55 of Title 10, United States Code; or
5. similar supplemental coverage provided to coverage under a group health plan.

Creditable Coverage does not include either of the following, if offered as independent, non-coordinated benefits: 1. coverage only for a specified disease or sickness; or 2. Hospital indemnity or fixed indemnity insurance.

Custodial Care - Care and services that assist an individual in the activities of daily living.

Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Designated Medical Conversion Carrier - The insurance company with whom the Company has contracted to provide medical conversion coverage.

Dependent - Refer to Section 3, "Covered Person Eligibility", for details.

Deductible - The amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- placing the Covered Person's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
 - 1) there is inadequate time to effect safe transfer to another Hospital prior to delivery or
 - 2) a transfer poses a threat to the health and safety of the Covered Person or unborn child.

Emergency Services. Medical screening, examination and evaluation by a Physician or other personnel - to the extent provided by law - to determine if an Emergency Medical Condition or psychiatric emergency medical condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric emergency medical condition within the capabilities of the facility.

Employer means the Group Policyholder and/or any employer approved by the Company for participation in the coverage provided by the Policy.

Experimental or Investigational - Refer to Section 1, "Limitations of Benefits", for details.

Facility means a health care or residential facility that is duly accredited by and licensed by the state in which it operates to provide medical inpatient, residential day treatment, partial hospitalization, skilled nursing care or Outpatient services or a facility for the diagnosis or treatment of Chemical Dependency or Severe Mental Illness.

Family - The Insured Person and his or her Dependent(s) who are insured under the Policy.

Full-Time Employee means an employee of the Employer:

1. whose employment with the Employer is the employee's principal occupation; and
2. who is regularly scheduled to work at such occupation at least the minimum number of hours shown in the Policy Information Page.

Group Policyholder - The person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.

Home Health Care Agency means an organization duly licensed and certified or otherwise authorized as a home health care agency pursuant to the laws of the state in which the Covered Person resides and meets Medicare's requirements for home health care agencies and which is engaged in arranging and providing nursing services, Home Health Care services, and other therapeutic and related services.

Home Health Care means the home health care provided by a certified Home Health Care Agency according to a Physician's written treatment plan for care of a Covered Person in the Covered Person's place of residence. Services appropriate to the needs of the individual patient are planned, coordinated and made available through a multidisciplinary health team.

Hospice - Specialized form of interdisciplinary health care for a Covered Person with a life expectancy of 6 months or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Covered Person who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary care giver and family of the Covered Person receiving Hospice services.

Hospital - means an acute care Facility operated pursuant to state laws and:

1. Is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare program;
2. Is primarily engaged in providing, for compensation from its patients, diagnostic and surgical facilities for the care and treatment of injured or sick individuals by or under the care of a staff of Physicians;
3. has 24-hour nursing services by registered nurses; and
4. is not primarily a place for rest of Custodial Care, or a nursing home, convalescent home or similar institution.

Injury - Bodily injury due to an Accident occurring while a Covered Person is insured under the terms and conditions of the Policy.

Insurance Month - period of time:

1. beginning at 12:00 AM Standard Time at the Group Policyholder's principal location on the first day of any calendar month; and
2. ending at 11:59 PM on the last day of the same calendar month.

Insured Person - The person enrolled in the Health Plan for whom the appropriate premiums have been received by the Company and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Inpatient - Registered as an inpatient in a Hospital or a Facility upon the recommendation of a Provider, and incurring charges for room and board.

Inpatient Services - Those Covered Services provided to a Covered Person in a Hospital or Skilled Nursing Facility bed that is not in the Outpatient department of such institution.

Late Enrollee - An employee who declined enrollment in the Policy when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Limiting Age - The age established by the Group Policyholder when a Family Member is no longer eligible to be enrolled under the Insured's coverage.

Limited Fee Schedule means the Company's Limited Fee Schedule that is based on the relative value unit schedule and dollar amount conversion factors or comparable amount and used to determine the Covered Expense by the Company for services or supplies provided by a Non-Participating Provider. Any charges incurred for services or supplies by a Non-Participating Provider that exceed the maximum amount of the Limited Fee Schedule will not be a Covered Expense. Please refer to your Schedule of Benefits to determine if the Limited Fee Schedule is applicable to your group policy.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of PacifiCare, it is all of the following:

- (a) A health intervention for the purpose of treating a medical condition;
- (b) The most appropriate supply or level of service, considering potential benefits and harms to the Covered Person;
- (c) Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- (d) If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Covered Person.

A service or item will be covered under the Company health plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and *Medically Necessary*. An intervention may be medically indicated yet not be a covered benefit or meet the definition of *Medical Necessity*.

In applying the above definition of *Medical Necessity*, the following terms shall have the following meanings:

- (i) *Treating Physician* means a Physician who has personally evaluated the patient.
- (ii) *A health intervention* is an item or service delivered or undertaken primarily to *treat* (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, sickness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.
- (iii) *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- (iv) *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

- (v) *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrates the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- (vi) A *new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- (vii) An intervention is considered *cost effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Medicare - The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare Eligible - Those Covered Persons who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

National Preferred Transplant Network - A network of transplant facilities that are:

- Licensed in the State in which they operate;
- Certified by Medicare as a transplant facility for a specific organ transplant; and
- Satisfies PacifiCare's quality of care standards to be designated by PacifiCare as a transplant facility for a specific organ program. National Preferred Transplant Network facilities may be located outside the state based on a number of factors including quality, cost and outcomes.

Note: Regional Organ Procurement Agency is defined as an organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Neuromuscular Skeletal Disorders - Misalignments of skeletal structures and muscular weaknesses, imbalance and disorders related to the spinal cord, neck and joints. All such disorders must be documented and demonstrated through x-rays or bodily function limitations.

Non-Participating Provider - a Hospital, Physician, Facility or other health care Provider who has not contracted with the Company or the Company's designated Preferred Provider Organization.

Open Enrollment Period - The period of time as specified in the application of the Group Policyholder and approved by the Company during which Persons may enroll themselves and their eligible Dependents under the Policy. The Open Enrollment Period, if any, is shown on the Policy Information Page.

Outpatient - Treatment from a Provider in a Facility other than on an inpatient basis.

Participating Provider - A Hospital, Physician, Facility or other health care Provider who has contracted with the Company or the Company's designated Preferred Provider Organization to provide services, treatment and supplies to a Covered Person at negotiated fees.

Percentage Payable - means the benefits payable under the Policy which are a percentage of the Covered Expense in excess of all Deductibles and Copayments. The Percentage Payable for each type of Covered Service is set forth in the Schedule of Benefits.

Person - a Full-Time Employee of the Employer:

1. who is a member of an employee class which is eligible for coverage under the Policy; and
2. who has completed an enrollment card approved by the Company.

Physician - Any licensed doctor of allopathic or osteopathic who is practicing within the scope of his or her licensure and any other practitioner of the healing arts who renders services within the scope of his or her licensure.

Policy - the Group Health Insurance Policy issued by the Company to the Group Policyholder.

Policy Anniversary - The annual date stated as the "Policy Anniversary" on the Policy Information Page of the Policy.

Policy Effective Date - The date stated as the "Policy Effective Date" on the Policy Information Page of the Policy.

Policy Maximum - the maximum amount of benefits payable under the Policy for all Covered Expenses incurred by a Covered Person while insured under the Policy. The Policy Maximum shown on the Schedule of Benefits. No further benefits will be paid after a Covered Person reaches the Policy Maximum, and such Covered Person will no longer be insured under the Policy.

Preauthorization means the medical review process that examines the Medical Necessity procedure or service and that must be obtained by the Covered Person from the Company before receiving such procedure or service from a Provider. If Preauthorization is required, it must be obtained to avoid a reduction in benefits under the Policy.

Pre-Existing Condition - any condition, other than pregnancy, for which medical advice, diagnosis,

care, or treatment was recommended or received within the 6-month period ending on:

1. the first day of the Waiting Period for an Insured Person or a Dependent who was enrolled within 31 days of the date the Person first became eligible for coverage under the Policy; or
2. the Effective Date of coverage for all other Covered Persons.

Premiums - The payments made to the Company by an Group Policyholder on behalf of an Covered Persons for the covered period under the Policy.

Primary Residence - Primary Residence is the home or address where the Covered Person actually lives most of the time. A residence will no longer be considered a Primary Residence if: 1) The Covered Person moves without intent to return; 2) the Covered Person is absent from the residence for 90 consecutive days, or 3) the Covered Person is absent from the residence for more than 100 days in any six month period.

Prosthetic(s) - Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

Provider - A person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Certificate and Schedule of Benefits*.

Provider Directory - A current list of Participating Providers, which shall be made available to each Covered Person through the Employer.

Prudent Layperson - A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Rehabilitation Services - The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by Sickness or Injury.

Replaced Plan means a similar health benefits policy or plan that was issued to the Group Policyholder and which the Policy replaced.

Respite Care - the short-term services provided to Covered Persons receiving authorized Hospice services who have disabilities that require care and/or supervision while allowing the caregivers temporary relief. Services may be provided:

1. In a nursing home or Hospital, and includes personal care, nursing intervention, supervision, meal preparation, and a room.
2. In an adult foster care home or personal care home, and includes personal care, housekeeping, supervision, meal preparation, transportation, and a room.
3. In an adult day health care facility, and includes personal care, nursing services, supervision, meal preparation, and transportation

In the individual's own home by a home care attendant or primary caregiver, and includes personal care, housekeeping, meal preparation, supervision, and transportation. Refer to Section 1, "Hospice Services", for details.

Schedule of Benefits - An important part of this *Certificate* that provides additional benefit information including Coinsurance, Copayment, Deductible and Limitation Information.

Semi-Private Room Rate - the most common charge for a two bed room in a Hospital, Facility, or Skilled Nursing Facility, as determined by the Company.

Serious Emotional Disturbances of a Child - A Serious Emotional Disturbance (SED) of a child is defined as a child who:

1. Has one or more mental disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms;
2. Is under the age of 18 years old; and
3. Meets one or more of the following criteria:
 - a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning; family relationships or ability to function in the community; and either of the following occur:
 - i. the child is at risk of removal from home or has already been removed from the home;
 - ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
 - b. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a mental disorder; or
 - c. The child meets special education eligibility requirement under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

Severe Mental Illness - Severe Mental Illness (SMI) includes the diagnosis and Medically Necessary treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism
- Schizoaffective Disorder
- Schizophrenia

Sickness - a physical illness, disease or complication of pregnancy, but does not include Severe Mental Illness. The term "Sickness," when applied to the Insured Person or the Insured Person's covered Dependent Spouse, will include pregnancy and resulting childbirth.

Significant Break in Coverage - A period of 63 consecutive days during all of which an individual does not have any Creditable Coverage. Waiting periods and HMO affiliation periods during which an individual does not have coverage are not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Care - The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

Skilled Nursing Facility - A comprehensive freestanding rehabilitation facility or a specially designed unit within a Hospital licensed by the state in which it is doing business to provide Skilled Nursing Care.

Skilled Rehabilitation Care - The care provided directly by or under the direct supervision of a licensed Provider acting within the scope of his or her licensure.

Special Enrollment Period means a period of time, mandated by the Health Insurance Portability and Accountability Act of 1996, where Persons or Dependents who are not insured under the Policy may enroll for coverage as specified in the Special Enrollment provision.

Spouse - The Insured Person's legally recognized husband or wife under the laws of the state in which the Group Policy is delivered.

Subacute and Transitional Care - Subacute and Transitional Care are levels of care needed by a Covered Person who does not require Hospital acute care but who requires more intensive licensed Skill Nursing Care than is provided to the majority of the patients in a Skilled Nursing Facility.

Temporomandibular Joint Syndrome - A condition affecting the upper or lower jawbone, or associated bone joints, that is unrelated to any external traumatic episode.

Totally Disabled or Total Disability - For Insureds, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an Injury or Sickness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an Injury or Sickness.

Transitional Care See "Subacute Care."

Urgent Care - means Covered Services rendered at an Urgent Care Facility which are appropriate to the treatment of an Injury or Sickness that is not a life-threatening Emergency, but requires prompt medical attention. Urgent Care includes the treatment of minor Injuries as a result of Accidents, the relief or elimination of acute pain, or the moderation of an acute Sickness.

Usual and Customary means the lesser of:

1. a Provider's usual charge for furnishing treatment, service or a supply; or
2. the charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area and whose Injury or Sickness is comparable in nature and severity.

Please refer to your Schedule of Benefits to determine if a Usual and Customary Charge is applicable to your group policy.