CONTRACT FOR

LOGAN CITY

EFFECTIVE DATE JULY 1ST 2014

Arches HEALTH PLAN

The Way Healthcare Gets Better™

CITY OF LOGAN
HEALTH INSURANCE CONTRACT

Arches Mutual Insurance Company, dba Arches Health Plan, a Utah non-profit COOP (Arches) agrees to provide the health care benefits described in this Contract to eligible employees of City of Logan (Group) and their eligible dependents, who become enrolled under this Contract. The Agreement, including the Group's Application, for Group Health Insurance between Arches and City of Logan consists of: 1. the terms and conditions set forth in this Contract; 2. Plan Summary and Summary of Benefits and Coverage (SBC) (Exhibit A); Rates, Plans, and Coverage Periods (Exhibit B); and 3. the Group Policy which pertains to City of Logan (Exhibit C).

In this Contract, the terms "We," "Us," and "Our" refer to Arches Health Plan and the term "Group" means City of Logan, whose employees may participate under this coverage. "Enrolled Employee" means an employee of the Group who is eligible under the terms of this Contract, has completed an enrollment form and is enrolled under this Contract. "Enrolled Dependent" means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's application, has completed an enrollment form and is enrolled under this Contract. The term "Member" refers to an Enrolled Employee or an Enrolled Dependent. Other terms are defined where they are first used or in the definitions section of the Group Policy.

ARCHES HEALTH PLAN
Linn J. Baker
Chief Executive Officer

Arches Mutual Insurance Company Contract

This Contract, including the Group's application, Plan Summary and Summary of Benefits and Coverage (SBC) (Exhibit A): Rates, Plans, and Coverage Periods (Exhibit B), the Group Policy (Exhibit C) and any amendments, endorsements or riders and any subsequent renewals thereof constitute and is the entire agreement between City of Logan (Group) and Arches Health Plan concerning the subject matter of this Contract. It states all the terms of the coverage and supersedes and cancels all and any prior contracts issued to the Group by Us. No modifications of or additions to this Contract will be binding upon Us unless set forth in an amendment, endorsement or rider issued by Us and signed by one of Our authorized officers.

GROUP ELIGIBILITY

The Group must continuously satisfy the requirements of this section, this Contract and the Group's application in order to become enrolled and remain enrolled under this Contract.

GROUP QUALIFICATIONS

In order to qualify as an employer and to maintain eligibility for this employer health insurance Contract, the Group must be a bona fide person (including sole proprietors or self-employed individuals), firm, corporation (including Limited Liability Corporations, or LLCs), partnership (including Limited Liability Partnerships (LLPs)), labor union or political subdivision. In order to be eligible, a Group must:

- accept billing on a consolidated basis and collect any required employee contributions via payroll deductions;
- be actively engaged in legal business activity;
- be licensed to conduct business in the state and obtain other business licenses as required by law;
- employ at least two employees on the first day of the plan year with a normal work week of the number of hours indicated in the Group's application, the majority (75 percent or more) of whom are employed within Our service area and with which a bona fide employer-employee relationship exists; and
- have a status as a legal entity with authority to contract for health insurance coverage and not be formed primarily for purposes of buying health insurance.

Employer Contribution and Employee and Dependent Participation

Coverage under this Contract is contingent upon the Group satisfying all eligibility, participation, Group size, contribution and other requirements as specified in the Group's application.

MEMBER ELIGIBILITY

The following sections describe employee and dependent eligibility under this Contract. The Eligibility criteria are specified in the Group Policy and the Group Application. The Group agrees that We have the right to examine employee records for purposes of confirming any Member's employment status.

EMPLOYEE ELIGIBILITY

To enroll and remain eligible under this Contract, an individual must meet **all of the following requirements** on a continuous basis (except that eligibility commences or continues while an employee is otherwise eligible but is confined to a Hospital, Skilled Nursing Facility or extended care facility):

- have begun performing personal services for the Group;
- be and remain a permanent, active, full-time employee of the Group working the required number of hours;
- be classified by the Group as its employee for all purposes, including determination of eligibility for coverage under the group health plan;
- be in an employer/employee relationship as defined by federal tax law;
- have completed any applicable probationary period as required by the Group;

- have contributions toward the cost of coverage (if any) withheld via payroll deduction; and
- not be classified as a part-time, leased, temporary, seasonal or substitute employee, or as an independent contractor or a person whose earnings are reported on IRS Form 1099.

DEPENDENT ELIGIBILITY

Eligible dependents, which are described in detail in the Group Policy, include an Enrolled Employee's legal spouse or qualified domestic partner and children of the Enrolled Employee or qualified domestic partner.

TERM, MODIFICATION, TERMINATION

Term

This Contract goes into effect on July 1, 2014. This is the Contract Effective Date. The date this Contract is renewed is the Renewal Date. The Renewal Date is July 1 of each year. The Contract will remain in effect from one Renewal Date to the next unless otherwise terminated as described in the "renewal and termination" provision.

Modification

We have the right to modify or amend any provision of this Contract, including premium rates, on any Renewal Date by giving the Group at least 30 days (or longer, as required by law) advance written notice. No modification or amendment will be effective until at least 30 days after such advance notice has been given. Any modification will be uniform within the product line and at the time of renewal.

However, when a change in the Contract is beyond Our control (e.g., legislative or regulatory changes take place, the Group size increases or decreases by ten or more percent or the Group initiates a benefit change), We may modify or amend the Contract on a date other than the Renewal Date, including changing the premium rates, as of the date of the change in the Contract. We will give the Group prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify the Group in writing of a change of premium rates within 30 days after:

- the later of the effective date or the date of Our implementation of a statute or regulation;
- the Premium Due Date following Our knowledge of a Group size change of ten percent or more; or
- reaching agreement with the Group on a Group-initiated benefit change.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in the Contract is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Group's acceptance of a premium rate change.

Changes can be made only through a modified Contract, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Contract.

Renewal and Termination

The Contract is renewable at the option of the Group, except that We may discontinue or non renew this Contract with no less than 30 days written notice if there is no longer any Member covered through the Group who lives, resides or works in Our service area or in the area in which We are authorized to do business.
We may also discontinue this Contract or coverage for a Member on any Premium Due Date with written notice and/or re-rate and collect any additional funds from the Group as follows:

- For the Group's failure to pay the required premiums by the end of the grace period (also see "Payment of Premiums" below).
- For fraud or intentional misrepresentation of material fact by the Group.

- For the Group's failure to provide Us quarterly withholding information necessary to validate eligible employees or failure to respond to Our written request for current status information including group size, participation and contribution.
- For the Group's failure to comply with Our minimum participation requirements or employer contribution requirements.

In addition, if We choose to discontinue offering coverage in the small group (2 through 50 employees) and/or large group (over 50 employees) market, We will provide 180-days prior written notice to affected groups and Members.

In the event We eliminate the coverage described in this Contract for the Group and all other enrolled groups, We will provide 90-days written notice to the Group and all Members covered through the Group. We will make available to the Group, on a guaranteed issue basis and without regard to the claims experience of the Group or health status of any Member covered through it, the option to purchase all other group coverage(s) being offered by Us for which the Group qualifies.

The Group may terminate this Contract on any Premium Due Date upon 35 days prior written notice to Us.

The Group shall provide each Enrolled Employee 30 days prior written notice of termination and notify the Enrolled Employee and Enrolled Dependents of any right which may exist to continue coverage upon termination.

Retroactive Termination of Members

The Group may not retroactively terminate a Member except in cases of fraud or intentional misrepresentation of material fact. However, it may be possible for the Group to retroactively terminate a Member, if all of the following conditions are met: 1) the Contract covers only active employees (or those on COBRA); 2) the Member has paid no premium for coverage after the effective date of the cancellation; 3) the Member had no expectation of coverage after the requested effective date of cancellation; and 4) the retroactive cancellation is due to a delay in administrative record-keeping that occurred in the normal course of business. If a Member for which the Group requests retroactive termination incurs expenses and We pay claims after the requested termination date, premium is due and must be paid for that Member for the monthly period in which claims are incurred.

PREMIUMS

When are Premiums Due?

All premium, any charges or fees for this Group Policy (hereinafter referred to as “premium”) must be paid to Us by You. The premium due under this Group Policy on each Premium Due Date will be the sum of the premium charges for the insurance provided under this Group Policy. It is Your responsibility to collect any premium contributions required by Covered Employees for their coverage under this Group Policy. If You do not pay premiums when due, this Group Policy will terminate subject to the *Grace Period*. The Premium Due Date is shown on the cover page of this Group Policy.

Grace Period

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. Coverage under this Group Policy will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, this Group Policy will automatically terminate at the end of the Grace Period. If this Group Policy was purchased on the Exchange, this Grace Period provision will be subject to any Exchange rules governing the grace period for payment of premiums.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state of Utah, where this Group Policy is issued, We may change the rates for this Group Policy on any Policy Anniversary Date. We will give You at least 45 days advance written notice prior to the effective date of any rate change.

Refunds of Premiums

If premiums are paid for someone who is not eligible for coverage, We shall refund the amount paid in error as long as no claims have been paid for expenses incurred during the period of noneligibility. If We have paid claims for the Member in question, premium is due and must be paid for that Member during the period in which claims are incurred.
In the event this Contract is terminated, We shall refund any unearned premiums to the Group. In the event this Contract is terminated because of material misrepresentation, We shall refund to the Group any unearned premiums less the amount of paid claims.

OUT-OF-AREA SERVICES

We have a relationship with Coventry for "Out of Area Services." Whenever Members access health care services outside the geographic area We serve, the claim for those services may be processed and presented to Us for payment. Members may obtain care from nonparticipating Providers for urgent and emergent care, with the claim for those services processed and presented to Us for payment.

GENERAL PROVISIONS

Group Responsibilities

The Group agrees to the following:

- Handle and distribute enrollment materials in a timely manner and promptly provide to Us the information necessary to administer this Contract. There is an understanding and agreement that the Group's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.
- Pay Enrolled Employees on a regular, periodic basis through the Group's payroll system and withhold federal and state taxes (including FICA) via payroll deduction.
- Restrict enrollment and payment of premiums through the Group to eligible Members.
- Make payroll deductions for and verify with Us the eligibility of any Member on a temporary leave of absence.
- Remit premiums for a terminating Member through the end of the monthly coverage period in which the Member terminates (except as provided under Refund of Premiums), unless otherwise agreed in advance in writing.
- Delete terminations from the billing and to notify Us of terminations in a timely manner and as part of the administrative record-keeping process that occurs in the normal course of business. The Group further agrees that any refund of the number of months of premiums paid by the Group in error or for an ineligible Member shall be made only if claims have not been paid.
- Provide each Member 30 days prior written notice of termination of this Contract, including any termination due to the Group's failure to pay premiums.
- Notify each Member of any right(s) that may exist to continue coverage upon termination, as provided by any applicable law or as otherwise described in the Group Policy, and collect and forward associated timely enrollment forms and premiums.
- Provide those notices, in a timely manner, that a group health plan is required by law to provide (special enrollment rights provisions). The Group agrees to indemnify and hold Us harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such legally-required notices.
- Report monthly the names of new Members, cancelled Members and Members electing any statutory continuance of coverage.
- Maintain workers' compensation insurance on all employees legally required to be so insured (or self-insure workers' compensation coverage of such employees).
- Maintain Group eligibility in accordance with the minimum standards of applicable statutory

continuances of coverage, unless We have agreed in advance and in writing to the Group's use of standards more generous to Members.

- If We provide Our enrollment and/or change forms ("Forms") and/or any summary plan descriptions, benefit summaries and/or comparison sheets ("Documents") in an electronic medium for inclusion on the Group's internal intranet or by similar means, Group agrees that:
  - electronic access shall be limited to the Group's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;
  - they will replace any hard-copy Forms that have been modified by Us;
  - the hard-copy documents on file with Us shall control in the event of any discrepancy; and
  - the Group remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g., distribution).

NOTICE UNDER THIS CONTRACT

Any notice required under this Contract shall be deemed to be properly given if written notice is deposited in the United States mail or with a private mail carrier. Notices to an Enrolled Employee or to the Group shall be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward any notice for an Enrolled Employee to the Group administrator if We become aware that We do not have a valid mailing address for the Enrolled Employee.
Any notice to Us will not be deemed to have been given to and received by Us until physically received by Us. Notices the Group gives to Us must be sent to Us at Our principal mailing address of:

Arches Health Plan
5505 South 900 East, Suite 100
Salt Lake City, Utah 84117

Choice of Forum

Any legal action arising out of this Contract must be filed in a court in the state of Utah.

Governing Law and Discretionary Language

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the State of Utah without regard to its conflict of law rules. As the plan administrator, the Group delegates Us discretion for the purposes of paying benefits under the benefit plan only if We determine that You are entitled to them and of interpreting the terms and conditions of the benefit plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of Our determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the benefit plan. We are not the plan administrator, but are an insurance company that provides insurance to this benefit plan, and the court will determine the level of discretion that it will accord Our determinations.

Arbitration

Any controversy or claim between the Group and Us arising out of or relating to this Contract, or the breach thereof, whether involving a claim in tort, contract or otherwise, shall be subject to final resolution through binding arbitration. The parties agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in the state of Utah, unless mutually agreed otherwise by the parties.
If any Member or former Member (or person claiming to be a Member or former Member) makes any claim or brings any action or proceeding arising out of or relating to this Contract to which We or the Group become a party, We and/or the Group agree to cooperate in the defense of such claim, action or proceeding and to resolve any controversy or claim between Us and the Group through arbitration under this paragraph only after the resolution of the Member's (or alleged

Member's) claim.

No Waiver
The failure or refusal of either party to demand strict performance of this Contract or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of this Contract will be deemed waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

Representations Are Not Warranties
In the absence of fraud, all statements made in an application by the Group or an enrollment form by an enrolled person shall be deemed representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written document signed by the Group or the enrolled person, a copy of which has been furnished to the Group or the enrolled person.

Our Receivership or Liquidation
If receivership or liquidation proceedings are commenced with respect to Us, and if this Contract has not otherwise been terminated, then the Group may suspend all further performance of this Contract pursuant to any applicable provisions of federal or state law. Any such suspension or further performance by the Group pending the assumption or rejection of the Contract shall not be deemed a breach of the Contract and shall not affect the Group's right to pursue or enforce any of the rights under this Contract or otherwise. In the event of Our receivership or liquidation brought under Utah State law, the Group and its Members have the right to file claims with the appointed receiver or the Utah Life and Health Insurance Guaranty Association (ULHIGA), as set forth in Utah Code, Title 31A, Chapters 27 or 28, as applicable.

Funding
The Group shall adopt policies and procedures regarding the funding of the Group's payment obligations under this Contract. This includes the withholding of premiums by payroll deduction from Enrolled Employees' wages and/or the payment of the Group's contributions from the general assets of the Group. Amounts paid (either directly or withheld by payroll deduction) by Members for benefits under the plan shall be used for the exclusive benefit of the Members and neither the Group nor the ERISA plan administrator shall divert such amounts for any purpose other than for the payment of the Group's obligations hereunder. Amounts paid (either directly or withheld by payroll deduction) by Members shall be transferred to Us by the Group prior to the payment of Group contributions from the general assets of the Group.

Certificates of Creditable Coverage
We will provide certificates of creditable coverage to Members terminating from the Group, unless the Group specifically notifies Us in writing that it will provide such certificates of creditable coverage to terminating Members. The Group understands and agrees that Our timely provision of certificates of creditable coverage depends upon the Group's prompt deletion of terminating Members from the Group's billing. It agrees to indemnify and hold Us harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to Our failure to provide a certificate of creditable coverage in a timely manner as a result of the Group's failure to promptly delete a terminating Member from the Group's billing.

Group Is Agent
The Group is the agent of the Members for all purposes under this Contract and not the agent of Arches Health Plan. Members are entitled to health care benefits pursuant to this agreement between Us and the Group. The Group agrees to act as agent for Members in acknowledging their agreement of the terms, provisions, limitations and exclusions contained in this Contract and the Group Policy and to act in a timely and diligent manner as the agent of the group for certain purposes, such as enrollment and termination procedures, providing consent to release information.

COBRA CONTINUATION OF COVERAGE

This section applies only when the benefit plan is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Certain circumstances, called qualifying events, give Members the right to continue this coverage beyond

the time it ordinarily would have ended. COBRA continuation rights and obligations are governed by the COBRA law, as amended, and if there is any conflict between the provisions of this Contract and COBRA, COBRA's minimum requirements will govern. This section will automatically cease to apply when federal law requiring COBRA continuation no longer applies to the benefit plan. This section does not provide a full description of COBRA. Additional provisions of COBRA are specified in the Group Policy.

IN WITNESS WHEREOF, this Agreement is executed as of the 1st day of July, 2014.

ARCHES HEALTH PLAN

By _____

Its _____

CITY OF LOGAN

By _____

Its _____

EXHIBIT A

Plan Summary and Summary of Benefits and Coverage (SBC)

LOGAN CITY
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

Plan Effective from 7/1/2014 through 6/30/2015

GENERAL INFORMATION	IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Annual of Lifetime Maximum Plan Benefits	Unlimited Benefit Maximum	
Pre-Existing Limitations or Exclusions	No Exclusions For Pre-Existing Conditions	
Requirements for Pre-Authorization	Prior authorization is required for certain services in order to verify that the services to be provided are covered by your benefit plan and are medically necessary and appropriate. It is your responsibility to determine that providers and facilities have obtained prior authorization from Arches Health Plan prior to receiving care. If prior authorization is not obtained, coverage may be denied.	
Use of Participating Providers	Services are excluded if rendered by providers or facilities that, at the time of service, are not participating in the network. This exclusion does not apply to emergency care or urgent care outside of Utah.	
DEDUCTIBLES AND OUT OF POCKET LIMITATIONS (CALENDAR YEAR)	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Deductible - Individual Coverage	$2,500	$2,500
Deductible - Family Coverage *Deductible is cumulative, no 1 person will meet deductible until family deductible has been met*	$5,000	$5,000
Out of Pocket - Individual Coverage *The out of pocket limit is the maximum amount of cost-sharing you are expected to pay during a calendar year. All required deductibles and copayments are included in your out of pocket limit. Once you have met your out of pocket limit, Arches Health Plan will pay 100% of your covered charges for the remainder of the calendar year.*	$2,500	$5,000
Out of Pocket - Family Coverage *Out of Pocket is cumulative, no 1 person will have met out of pocket maximum until family out of pocket has been met.*	$5,000	$10,000
Co-Insurance For Covered Services Not Addressed	0% After Deductible	20% After Deductible
INPATIENT SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Inpatient Hospital, Surgical or Medical - Facility and Ancillary Services and Supplies - Physician Services (except maternity) - Implanted Prosthetic Devices	0% After Deductible	20% After Deductible
Maternity Physician Services *Includes all charges included in Global Fee, see inpatient hospital benefit for facility charges.*	0% After Deductible	20% After Deductible
Skilled Nursing / Rehabilitation Facility *Limited to a combined 30 days per calendar year*	0% After Deductible	20% After Deductible
Hospice Facility *Limited to 6 months every 3 years*	0% After Deductible	20% After Deductible
Mental Health or Substance Abuse Facility	0% After Deductible	20% After Deductible
OUTPATIENT SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Preventive Care	No Cost to Member	Not Covered
Primary Care Office Visits	0% After Deductible	20% After Deductible
Specialist Office Visits	0% After Deductible	20% After Deductible
Eye Exam - Optometrist	0% After Deductible	20% After Deductible
After Hours or Urgent Care Clinic	0% After Deductible	20% After Deductible
Mental Health or Substance Abuse Office Visit	0% After Deductible	20% After Deductible
Rehabilitation or Habilitation Services *Limited to 20 combined visits per year*	0% After Deductible	20% After Deductible
Outpatient Surgical Procedures - Facility or Surgical Suite Fee	0% After Deductible	20% After Deductible
- Physician Fee	0% After Deductible	20% After Deductible
Minor Diagnostics Services	0% After Deductible	20% After Deductible
Specific Major Diagnostic Services		
- CAT Scans, MRIs, MRAs, and Electron Beam Scans	0% After Deductible	20% After Deductible
- PET and SPECT Scans, and Nuclear Diagnostic Medicine	0% After Deductible	20% After Deductible

- Other major diagnostics	0% After Deductible	20% After Deductible
Medical Services Performed at an Outpatient Facility - Chemotherapy - Radiation Therapy - Cardio/Pulmonary Medical Services - Dialysis - Mental Health or Substance Abuse Acute Intervention	0% After Deductible	20% After Deductible
PRESCRIPTION BENEFITS	**PARTICIPATING PHARMACIES ONLY**	
COVENTRY FORMULARY & PROTOCOL		
Generic substitution and step therapy may be required. When a generic is available but the pharmacy dispenses the brand name drug for any reason other than the physician's order, the member will pay the appropriate brand name copay plus the difference in cost between the brand name and generic drug.		
Retail Drugs, Up to a 30 Day Supply		
- Tier 0 (Mandated)	Preventive Care - No Cost	
- Tier 1 (Preferred Generic)	0% After Deductible	
- Tier 2 (Preferred Brand Name)	0% After Deductible	
- Tier 3 (Non-Preferred Brand of Generic)	0% After Deductible	
- Specialty Drugs	0% After Deductible	
Mail Order Drugs, Up to a 90 Day Supply		
- Tier 0 (Mandated)	Not Available	
- Tier 1 (Preferred Generic)	0% After Deductible	
- Tier 2 (Preferred Brand Name)	0% After Deductible	
- Tier 3 (Non-Preferred Brand of Generic)	Not Available	
- Specialty Drugs	Not Available	
Preferred Insulin, Syringes, and other authorized diabetic supplies	Preventive Care - No Cost	
INJECTABLE OR IMPLANTABLE MEDICATIONS	**PARTICIPATING PHARMACIES & PROVIDERS ONLY**	
In general your provider will coordinate the process of obtaining these drugs. These drugs require pre-authorization from Arches Health Plan. Some of these drugs must be obtained through certain drug distributors.	Pharmacy Benefits Apply	
- If these drugs are administered at a physicians office	Office Visit Benefits Apply	
- If these drugs are administered in an infusion suite	Out Patient Benefits Apply	
- If these drugs are administered in your home, by a health care provider	Home Health Care Benefits Apply - Does Not Count Towards Annual Home Care Visit Limit	
EMERGENCY SERVICES		
Ambulance		
- Group Ambulance	0% After Deductible	
- Air Ambulance	0% After Deductible	
Emergency Room		
- Outpatient Services Without Hospital Admission	0% After Deductible	
- Services Resulting in Hospital Admission	0% After Deductible	
HOME HEALTH CARE SERVICES AND SUPPLIES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Hospice Care Provided at Home *Up to 6 months every 3 years*	0% After Deductible	20% After Deductible
Home Health Care Services Up to 30 visits per year	0% After Deductible	20% After Deductible
Covered Durable Medical Equipment *Arches Health Plan covers rental, repair or purchase of durable medical equipment, new or used, with authorization. Replacement of prosthetic devices and corrective appliances are only allowed when the existing device has become inoperable due to normal wear and tear or a substantive change in the members physical condition.*	0% After Deductible	20% After Deductible
Miscellaneous Medical Supplies	0% After Deductible	20% After Deductible

SPECIAL OR LIMITED BENEFITS	IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Abortions *Abortions are NOT generally covered except to save the life of the mother or when conception occurs by rape or incest, where a police report and medical records confirm criminal paternity.*	When Covered Medical and Surgical Benefits Apply	
Adoption Benefit *Child must be placed with member within 90 days of birth and finalized within one year of placement. Claim must be filed within one year of placement.*	Maximum of $4,000 Reimbursement for Covered Adoption Expenses. Applied to Normal Maternity Cost Share.	
Dietary Products for Hereditary Metabolic Disorder *Limited to specific formulated products for the treatment of error of amino acid or urea metabolism, while under the direction and supervision of a physician.*	0% After Deductible	20% After Deductible
Transplant Benefit *Organ and tissue transplant service, including, but not limited to, cornea, kidney, heart, lung, liver, pancreas, and bone marrow transplant services determined to be medically necessary by Arches Health Plan. Limited to: cornea, kidney, and liver transplants under age 18, and evaluation, treatment and therapy involving the use of myelobalative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support for children under the age of 18. Office visits and other services related to organ transplant may have additional copays.*	When Covered Inpatient or Outpatient Surgical Benefits Apply	
Chiropractic Services *Limit 10 visits per calendar year*	0% After Deductible	20% After Deductible
ALLERGY SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Testing (limited to 6 visits) *Excludes Cytoxic, Leukocyte Histamine Release, Mediator Release, Passive Cutaneous Transfer, Provocative Conjenctival, Provocotive Nasal, Rebuck Skin Window, Rinkel, Subcutaneous or Sublingual Provocative Food and Chemical Testing.*	0% After Deductible	20% After Deductible
Serum and Treatment *Excludes Allergoids, Autogenerous urine immunization, LEAP therapy, medical devices, Neutralization therapy, Photo-inactivated or Ploymerized extracts, and Oral desensitization / immunotherapy.*	0% After Deductible	20% After Deductible
Injection Therapy	0% After Deductible	20% After Deductible
EXCLUSIONS		
Standard Arches Health Plan Exclusions and Limitations Apply.		
Out of Network Medical Services	Paid at maximum allowable charge, providers may bill above and beyond allowable charges. These additional charges are not covered and do not apply to the out of pocket maximum.	

Below is an outline of general excluded services to give an idea of what is not covered. A complete list with specific exclusions, limitations, and other plan provisions will be provided upon request or when the benefit plan is issued.

EXCLUSIONS

- Services payable under Worker's Compensation
- Bariatric Surgery
- Biofeedback or Neurofeedback
- Inpatient or Outpatient Dental Hospitalization
- TMJ
- Long-term or Custodial Care
- Services Needed Due to Illegal Activity
- Gender Reassignment Treatment or Surgery
- Gene Therapy-
- Reversal of Sterilization
- Weight Loss Programs
- Methadone Therapy-
- Balloon Sinuplasty
- Lovass Therapy
- Magnetic Source Imaging
- Experimental or Investigational Treatment
- Routine Follow Up Care Provided in the ER
- Educational, Training, Work, or Court Ordered Mental Health
- Routine Drug Screening
- Hair Analysis, Trace Elements, or Dental Filling Toxicity
- Private Duty Nursing
- Adult Circumcision
- Ineligible Surgical Procedures or Related Complications
- Services or Items Primarily for Convenience while Inpatient
- Sclerotherapy of Varicose Veins
- Autopsy Procedures
- Acupuncture or Acupressure
- Cosmetic Surgery
- Dry Needling Procedures
- Clinical Trial
- Adult Dental
- Infertility & Assisted Reproductive Technologies
- Refractive Eye Surgery, Including Lasik
- Hearing Aids
- Routine Foot Care
- Sleep Apnea Diagnosis or Treatment
- Immunizations Required for Travel or Military Service
- Sexual Dysfunction
- Skin Tag Removal
- Intimal Medical Thickness Testing
- Whole Body Scanning
- Electrosleep or Electronarcosis Therapy
- Holistic of Homeopathic Treatments
- Certain Medical Equipment, Services, and Supplies
- Sublingual or Colorimetric Allergy Testing
- Molecular Diagnostic
- Wilderness Programs
- Abortion, Except as in Accordance with Utah Law
- Treatment Programs For Enuresis or Encopresis
- Autologous Blood Storage

PRESCRIPTION DRUG EXCLUSIONS

- Nonlegend Drugs Other Than Insulin
- Fluoride Supplements
- Cosmetic Prescription Drugs
- Diabetic Infusion Sets
- Experimental Drugs
- Anabolic Steroids
- Over the Counter Drugs not Requiring a Prescription
- Prescription Drugs used for Erectile Dysfunction
- Replacement Prescription Drugs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.archeshealth.org/Planbrochure.html or by calling 1-877-345-8908.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$2,500** Person/**$5,000** Family. Out of Network: **$2,500** Person/**$5,000** Family. Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always Jan 1). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In Network: **$2,500** person/**$5,000** family. Out of Network: **$5,000** person/**$10,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed Charges, Health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specified covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.archeshealth.org for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-345-8908, email to advocate@archeshealth.org, or visit us at www.archeshealth.org
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.archeshealth.org/planbrochure.html or call 1-877-345-8908 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% After Deductible	20% After Deductible	None
	Specialist visit	0% After Deductible	20% After Deductible	None
	Other practitioner office visit	0% After Deductible	20% After Deductible	In Conjunction With Primary Care Physician.
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	0% After Deductible	20% After Deductible	None
	Imaging (CT/PET scans, MRIs)	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.archeshealth.org	Preferred Generic drugs	0% After Deductible	Not Covered	Retail, Up To 30 Day Supply.
	Preferred brand drugs	0% After Deductible	Not Covered	
	Non-preferred brand or generic drugs	0% After Deductible	Not Covered	Retail up to 30 day supply. Benefits may be denied or reduced without preauthorization.
	Specialty drugs	0% After Deductible	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization.
	Physician/surgeon fees	0% After Deductible	20% After Deductible	
If you need immediate medical attention	Emergency room services	0% After Deductible		None
	Emergency medical transportation	0% After Deductible		None
	Urgent care	0% After Deductible	20% After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization.
	Physician/surgeon fee	0% After Deductible	20% After Deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization.
	Mental/Behavioral health inpatient services	0% After Deductible	20% After Deductible	
	Substance use disorder outpatient services	0% After Deductible	20% After Deductible	
	Substance use disorder inpatient services	0% After Deductible	20% After Deductible	
If you are pregnant	Prenatal and postnatal care	0% After Deductible	20% After Deductible	None
	Delivery and all inpatient services	0% After Deductible	20% After Deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization. Up to 30 visits per year.
	Rehabilitation services	0% After Deductible	20% After Deductible	Limited to 20 combined visits of habilitation and rehabilitation services per year.
	Habilitation services	0% After Deductible	20% After Deductible	
	Skilled nursing care	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization. Limited to 30 days per year.
	Durable medical equipment	0% After Deductible	20% After Deductible	Arches covers rental, repair or purchase of durable medical equipment, new or used, at our option. Replacement of prosthetic devices and corrective appliances are only allowed when the existing device has become inoperable due to normal wear and tear or a substantive change in the members physical condition. Preauthorization required for purchases or rentals of supplies over $500. Quantitative limits apply.
	Hospice service	0% After Deductible	20% After Deductible	Benefits may be denied or reduced without preauthorization. Limited to 6 months per 3 years

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one time per year.
	Glasses	0% After Deductible	Not Covered	Limited to one item per year.
	Dental check-up	Not Covered	Not Covered	Limited to once every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care while traveling outside the U.S.
- Private-duty nursing
- Weight loss program
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.archeshealth.org/planbrochure.html or call 1-877-345-8908 to request a copy.

For more information on your rights to continue coverage, contact the insurer at www.archeshealth.org or **1-877-345-8908**. You may also contact the Utah State insurance department at 801-538-3890 (Salt Lake City area), or 1-800-439-3805 (within the State of Utah), or https://insurance.utah.gov/.

Your Grievance and Appeals Rights:

The Utah Insurance Department has a staff of insurance experts available to help you understand your insurance coverage and answer your questions. If you have been unable to resolve a problem with your insurance company or agent, you may contact our staff for assistance, or file a written complaint. If your compliant involves health care insurance, please refer to the section below titled HEALTH INSURANCE COMPLAINTS.
Our consumer service personnel are available to assist you between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday by calling:
Salt Lake City area: 801-538-3890
In-state toll-free: 1-800-439-3805
Or by visiting https://insurance.utah.gov/complaint/

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-345-8908.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,890
- **Patient pays** $2,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays** $2,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,420
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

EXHIBIT B

Rates, Plans, and Coverage Periods

Arches
HEALTH PLAN

Arches Large Group Application

For Groups with 50+ eligible employees

REQUESTED EFFECTIVE DATE:

July 1, 2014

COMPANY INFORMATION

City of Logan
Legal Name of Company

DBA – If Any

290 N. 100 W.
Address

Logan	UT	Cache	84321
City	State	County	Zip

87-6000243	municipality	
Tax ID Number	Nature of Business	SIC Code

Mayor H. Craig Petersen	435-716-9004	craig.petersen@loganutah.org
Owner/CEO Name	Phone Number	Email Address
Greg Cox / HR Director	435-716-9046	greg.cox@loganutah.org
Primary Contact Name/Title	Phone Number	Email Address

1880	municipality
Date Business Established	Type of Organization (Corporation, LLC, Non-Profit, etc.)

*If company has been in business less than 1 year articles of incorporation documents or equivalent should be submitted.

Traveler's
Workers Compensation Carrier and Policy Number

None
List any employees / owners excluded from Workers Compensation Coverage

Is the business currently in Chapter 11, or has the business filed bankruptcy within the last 12 months? ☐ Yes ☒ No

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

New Hire Waiting Period Requirements:

EMPLOYEE CLASS	Date of Hire (DOH)	FOM Following DOH	FOM Following 30 Days	FOM Following 60 Days	90 Days
1:		X			
2:					

FOM = First of the Month

Coverage will termination at the end of the month following termination date.

Employer Contribution - Please indicate the % or $ amount you contribute towards the employee's coverage:

Employee 100% Dependent 100 %

DETAIL OF ENROLLMENT

Please attach a complete census of all full time eligible employees.

Total Number of Active Employees	628
NOT ELIGIBLE:	
Part Time	221
Seasonal	
Contracted / 1099	
Other _____	
ELIGIBLE:	
Full Time Eligible for Coverage in Utah	407
Full Time Eligible for Coverage outside Utah	
Full Time in Waiting Period	0
Total Number Enrolling on Arches Health Plan	334
Total Number of COBRA Participants Enrolling	7
Reasons for those not enrolling on Arches Health Plan	
*Waivers must complete the waiver section of the enrollment form	
Eligible but not enrolled:	
Covered Elsewhere	73
Waiving with no coverage	0

BILLING PREFERENCE

- ☐ Monthly Check: $25 billing fee will apply
- ☐ Automatic Bank Withdraw: Please complete ACH form

PRODUCER / BROKER INFORMATION

As a representative of the employer, I hereby appoint the following agent and/or agency as Producer of Record and authorize that person to represent our group with Arches Health Plan.

Producer Name	Email	Phone
Gordon Brown	gordon.brown@gbsbenefits.com	801-364-7233

Contact Name	Email	Phone

Agency: GBS Benefits

Address: 465 So 400 E, Suite 300

City	State	Zip
Salt Lake City	UT	84111

SIGNATURE OF UNDERSTANDING

- I am an authorized officer of the employer applying for coverage on behalf of this organization and its employees.
- I have completed and/or reviewed this document and attest to its accuracy to the best of my knowledge.
- We have taken the time to examine and understand the benefit plans offered by Arches, including the exclusions and limitations.
- I understand that this application is part of the Group Contract as issued by Arches and by signing below I agree that we are bound by the terms and conditions contained in that contract.
- We understand that many of Arches Health Plans are HMO's and provide non-emergency benefits only through preferred network providers.
- We understand that coverage is not bound until Arches Health Plan determines that the application meets underwriting guidelines for participation and that each eligible employee and any dependents are properly enrolled or waived for coverage.
- This employer will provide Arches Health Plan copies of payroll reports, time cards or other documentation necessary to verify the contribution and/or participation parameters indicated in this application.
- This agreement is governed by the laws of the State of Utah, except where superseded by federal law.

Employer Signature	Date
Greg Cox	April 2, 2014

Printed Name	Title
Greg Cox	HR Director

Producer Signature	Date
Gordon Brown	4/14/14

I certify that I have reviewed this application and this is true and complete to the best of my knowledge.

Proposal Assumptions

Arches Health Plan is proposed to be the sole health insurance carrier for this group's eligible employees and their dependents residing or working within our defined service areas. This proposal is made on the basis of information provided by the group, the group's agent and/or consultant to Arches Health Plan. If this information is found to be invalid, outdated or otherwise inaccurate, Arches reserves the right to adjust or withdraw this proposal. This proposal is contingent on properly completed enrollment including all employee membership applications, a signed master application for group coverage, signed benefit summaries and an initial binder check. Applications must be received and approved by the Arches Health Plan underwriting department prior to the proposed effective date. If the final and completed enrollment is received after the proposed effective date, Arches Health Plan reserves the right to delay the effective date or otherwise modify the terms or rates offered in this proposal. If the final and completed enrollment does not closely match the original information provided to Arches Health Plan used to generate this proposal, we may adjust the final rates or benefits to properly compensate for the new information. If the final and completed enrollment deviates by more than 15% of the original census information provided, Arches Health Plan reserves the right to withdraw or modify this proposal.

Basis of Quote

- Effective Date: 07/01/2014
- SIC Code: 9121
- Total Eligible Employees: 365
- Minimum Participation: 75% after eligible waivers
- Eligible Waivers:
  - Covered elsewhere with at least 60% actuarial value benefits.
- Not Eligible for Coverage
  - Less than 30 hour per week
  - Seasonal, Temporary or Contracted Employees
  - Employees residing outside of Utah
- Employer Contribution:
  - 100% all tiers
- Waiting Period for new hires:
  - First of the month following 30 days from full time hire date.
- Termination of coverage occur at the end of the month following loss of eligibility

Proposed Rates

Group Name: Logan City
Effective Date: July 1, 2014
Proposal Date: February 8, 2014

Plan One – QHDHP $2500 Deductible – 100% Coinsurance

Single	$335.90
Two Party	$722.10
Family	$990.80

Notes

- Rates are good for 12 months from effective date
- Rates may be adjusted if federal or state laws or regulations mandate that we adjust benefits.
- Arches Health Plan may audit our payroll deductions to verify compliance with contribution and participation assumptions.
- Rates include 3% commission payable to broker.

Arches HEALTH PLAN
The Way Healthcare Gets Better™

EXHIBIT C

Group Policy Pertaining to City of Logan*

***Modified from Policy filed with the Utah Insurance Department (UDI) to remove provisions not applicable to City of Logan. Policy filed with UDI available upon request.**

ARCHES MUTUAL INSURANCE COMPANY
5505 S 900 E, Suite 100
Salt Lake City, UT 84117
801 312 9860

LARGE GROUP COMPREHENSIVE HEALTH POLICY

Group Policyholder:	City of Logan
Group Policy Number:	7108011000
Group Policy Effective Date:	July 1, 2014
Premium Due Date:	First Day of the Month
Group Policy Renewal Date:	July 1, 2015, and every July 1 thereafter
Group Policy Anniversary Date:	July 1 of each year
Group Policy Delivery State:	Utah

In this Group Policy, the Group Policyholder is referred to as "You" or "Your". The Arches Mutual Insurance Company is referred to as "We", "Our", "Us", or "the Company.

This is a legal contract between the Group Policyholder and Arches Mutual Insurance Company. We will pay benefits in accordance with, and subject , to the terms of this Group Policy. This promise is based on the Group Policyholder's application and payment of required premium.

This Group Policy is delivered in the jurisdiction shown above and is governed by its laws. This Group Policy takes effect at 12:01 a.m. on the Group Policy Effective Date shown above.

PLEASE READ YOUR GROUP POLICY CAREFULLY.

Signed for the Arches Mutual Insurance Company.

Chief Exective Officer

Non-Contributory
Non-Participating – No Dividends

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SECTION **PAGE**

IMPORTANT INFORMATION REGARDING YOUR GROUP POLICY

Customer Services – Coventry Health Care of Utah

- Our Third-Party Administrator, Coventry Health Care of Utah (also referred to as "Coventry Health Care" in this Group Policy) administers the following services for this Group Policy.

  - Benefit Inquiries
  - Group Policyholder Services – For Policies purchased on the Exchange Only
    (For other Policies, contact Arches Mutual Insurance Company)
  - Claims
  - Preauthorization
  - Utilization Review Management Program
  - HMO Network Providers
  - Prescription Drug Benefit Program
  - Complaints, Grievances and Appeals

  - **Customer Service Department:** 1-855-488-0619

  - **Utilization Review Management Program**
    - Preauthorization – Phone Number 1-801-323-6440 or 1-800-879-0234
    - Preauthorization – Fax Number 1-801-323-6160 or 1-800-434-6250

  - **Appeals and Grievances Department**
    - Customer Service Department 1-855-488-0619

    - Address for written requests or inquiries:
      Coventry Health Care of Utah
      Appeals and Grievance Department
      10421 South Jordan Gateway, #400
      South Jordan, UT 84095

  - **Prescription Drug Benefit Program**
    - Provider Pharmacy Listing 1-855-323-6440
    - Prescription Drug Mail Order Services 1-855-323-6440

Customer Service – Pediatric Vision Care Benefit

- Our Third-Party Administrator, Vision Service Plan (VSP), administers the Pediatric Vision Care Benefit and Vision Network for this Group Policy.

  - Contact VSP for Customer Service: Telephone – (800) 877-7195 or (916) 851-5000
  - Address: VSP, 3333 Quality Drive, Rancho Cordova, CA 95670

Contact Arches Mutual Insurance Company

Please contact Us at any time for any inquiries or problems.

Arches Mutual Insurance Company
5505 S 900 E, Suite 100
Salt Lake City, UT 84117
801-312-9860
Website Address: www.archeshealth.org

IMPORTANT NOTICE:
Notice of Women's Health Cancer Rights Act

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), the Group Policy covers mastectomy in the treatment of cancer and reconstructive surgery after a mastectomy. If You are receiving benefits in connection with a mastectomy, coverage will be provided according to the Group Policy's benefit and Utilization Review Management Program criteria and in a manner determined in consultation with the attending Physician and the patient, for

1. All stages of reconstruction on the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable deductibles and copayment limitations consistent with those established for other benefits. Medical services received more than 5 years after a surgery covered under this section will not be considered a complication of such surgery.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered. All benefits are payable according to the Group Policy's Schedule of Benefits. Regular Preauthorization requirements apply.

IMPORTANT NOTICE:
Notice of Newborns' and Mothers' Health Protection Act

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the Policy provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. The act requires that maternity coverage provide for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of Cesarean section). However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours for Cesarean section).

SECTION 1 – DEFINITIONS

The following are key words used in this Group Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Schedule of Benefits or the provisions in which they appear in this Group Policy.

Accident means an unexpected traumatic incident or unusual strain which: (1) is identified by time and place or occurrence; (2) is identifiable by part of the body affected; (3) is caused by a specific event on a single day; (4) results in a bodily Injury. Accident does not mean an unintentional incident caused by or during medical treatment or surgery for an Illness or Injury.

Advanced Practice Nurse means a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the board pursuant to state law.

Maximum Allowable Fee means the maximum amount that a Participating Provider agrees contractually to accept as full payment for provide services for Covered Benefits under this Group Policy.

Annual Out-of-Pocket Maximum means the maximum amount that the Covered Person must pay every Policy year for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum, if any, is shown in the Schedule of Benefits. Unless otherwise specified, it applies to all Covered Benefits except the *Preventive Health Care Services Benefit.*

The Annual Out-of-Pocket Maximum includes the following:

1. Policy year Deductible
2. Copayments; and
3. Coinsurance.

When the Annual Out-of-Pocket Maximum is satisfied in the Policy year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Policy year. The Annual Out-of-Pocket Maximum must be satisfied each Policy year.

Family Limit for the Annual Out-of-Pocket Maximum
The Family Annual Out-of-Pocket Maximum will be satisfied in the Policy year when the total out-of-pocket expenses incurred by one or more insured family members equal the Family Annual Out-of-Pocket Maximum. The Family Annual Out-of-Pocket Maximum has to be met each Policy year.

Coinsurance means the percentage of the Maximum Allowable Fee payable by the Covered Person for Covered Medical Expenses incurred for Covered Benefits. After the Covered Person satisfies the Annual Out-of-Pocket Maximum during the Policy year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Policy year. The Coinsurance amount is shown in the Schedule of Benefits.

Copay or Copayment means a fixed dollar amount the Covered Person is required to pay for specifically listed Covered Benefits as shown in the Schedule of Benefits. The required Copayment must be paid before benefits are payable under this Group Policy. Copayments are generally paid to the Provider at time of service. Copayments do apply to the satisfaction of the Out of Pocket maximum.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is: (1) a Skilled Nursing Facility; (b) an Extended Care Facility; (3) an Extended Care Unit; or (4) a Transitional Care Unit.

A Convalescent Home is primarily be engaged in providing:

1. Continuous nursing care services;
2. Health-related services; and
3. Social services.

Such Convalescent Home services must be provided by or under the direction and supervision of a licensed registered nurse, on a 24-hour basis, for Ill or Injured persons during the convalescent state of their Illness or Injuries. A Convalescent Home is not, other than incidentally: (1) a rest home; (2) a home for custodial care; or (3) a home for the aged. It does not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

Covered Benefits means all services covered under this Group Policy as provided under *Section 5, Covered Benefits.* Covered Benefits are payable as shown in the Schedule of Benefits.

Covered Dependent means Covered Employee's lawful spouse or domestic partner, and any of the Covered Employee's Dependent Children (as defined in this Group Policy) who are insured under this Group Policy. A Covered Dependent must be listed on the Covered Employee's enrollment form for Coverage under this Group Policy. Any required premium for the Covered Dependent's coverage under this Group Policy must be paid.

Covered Employee means the Eligible Employee who is actively enrolled for coverage under this Group Policy.

Covered Medical Expense means expenses incurred for Medically Necessary services, supplies, and medications that are:

1. Based on the Maximum Allowable Fee;
2. Covered under this Group Policy;
3. Provided to the Covered Person by and/or prescribed by a Participating Provider for the diagnosis or treatment of an active Illness or Injury or maternity care; or
4. Preventive Care

The Covered Person must be charged for such services, supplies and medications.

Covered Person means the Covered Employee and/or his or her Covered Dependents.

Custodial Care means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

Deductible means the fixed dollar amount of Covered Medical Expenses that the Covered Person must incur for certain Covered Benefits before We begin paying benefits for them. The Deductible must be satisfied each Policy year by each Covered Person, except as provided under *"Family Deductible Limit"* provision. The Deductible is shown in the Schedule of Benefits. Only the Maximum Allowable Fee for Covered Medical Expenses is applied to the Deductible.

Family Deductible
The Family Deductible is an Aggregate Deductible. The Family Deductible will be satisfied during the Policy year when the total expenses paid toward the Family Deductible by two or more of Covered Employee's family members who are insured family members equal the Family Aggregate Deductible amount. The Family Aggregate Deductible must be met each Policy year.

Dependent means the Covered Employee's:

1. Lawful spouse or Domestic Partner; and
2. Dependent Child as defined in this Group Policy.

Dependent Child or Dependent Children means the Covered Employee's children who are:

1. Up to age 26, regardless of their place of residence, or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Group Policyowner in accordance with applicable state or federal law; and

2. Unmarried dependent Handicap Children age 26 and over. Refer to the definition of *Handicapped Child.*

A Dependent Child does not include a child who is enrolled for Medicare.

Domestic Partner means a person with whom the Covered Employee has entered into a Civil Union in accordance with state law where the Covered Employee resides, or into a Domestic Partnership.

Domestic Partnership or **Civil Union** means a long-term committed relationship of indefinite duration with a person which meets the following criteria:

1. The Covered Employee and his or her Domestic Partner have lived together for at least 12 months;
2. Neither the Covered Employee nor his or her Domestic Partner is married to anyone else or has another domestic partner;
3. The Covered Employee's Domestic Partner is at least 18 years of age;
4. The Covered Employee's Domestic Partner resides with the Covered Employee and intends to do so indefinitely;
5. The Covered Employee and his or her Domestic Partner have an exclusive mutual commitment that is intended to be permanent;
6. The Covered Employee and his or her Domestic Partner are jointly responsible for each other's common welfare and share financial obligations; and
7. The Covered Employee and his or her Domestic Partner meet the requirements for a Domestic Partnership or Civil Union in the state where You reside, if any.

Family Coverage means coverage for: (1) the Covered Employee; and (2) the Covered Employee's spouse or Domestic Partner; and/or (3) one or more of the Covered Employee's Dependent Children.

Handicapped Child means a child who is unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months and chiefly dependent upon You for support and maintenance since the child reached age 26.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:

1. Placing the Covered Person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Care Services means health care items or services furnished or required to evaluate and treat an Emergency Medical Condition. Such emergency care services must be provided by or ordered by a licensed health care provider in a Hospital's emergency room.

Exchange means the Health Insurance Marketplace through which qualified consumers can compare and purchase insurance from insurance companies. The state may operate a State-based Exchange, a Federally-Facilitated Exchange, or an Exchange in partnership with the federal Department of Health and Human Services. Exchanges are required by the Affordable Care Act.

Health Insurance Marketplace means: (1) a State-based Exchange; (2) a Federally-Facilitated Exchange; or (3) an Exchange in partnership with the federal Department of Health and Human Services.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

Home Infusion Therapy Agency means a health care facility that provides home infusion therapy services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

Hospice means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

1. An Inpatient hospice facility, which is a facility managed directly by a Medicare-certified hospice that meets all Medicare certification regulations for freestanding inpatient hospice facilities; and
2. A residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

Hospital means an institution which:

1. Is operated for the care and treatment of sick or injured persons as in-patients; and
2. On its premises or in facilities available to the hospital on a pre-arranged basis, meets fully each of the following requirements:
    a. It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
    b. It is under the supervision of a medical staff and has one or more Physicians available at all times; and
    c. It provides 24 hours a day service by registered graduate nurses (RNs).

A Covered Person will not be considered hospital confined if he or she is in a special unit of a hospital used as a nursing, rest, or convalescent home.

Hospital includes a licensed ambulatory surgical facility.

The term "Hospital" does not include the following even if such facilities are associated with a Hospital:

1. A nursing home;

2. A rest home;
3. A hospice facility;
4. A rehabilitation facility;
5. A skilled nursing facility;
6. A place for the mentally ill;
7. A Convalescent Home or nursing home;
8. A long-term, chronic care institution or facility providing the type of care listed above.

Hospital Stay means the time period, in days, in which the Covered Person is hospitalized. Hospital stays must be ordered by the Physician and be Medically Necessary. Hospital stays are subject to Preauthorization.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury. Illness includes pregnancy, childbirth and related medical conditions.

Indian has the same meaning as defined by Section 4 of the Indian Health Care Improvement Act.

Indian Services mean services for Covered Benefits that are provided directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. Services provided through referral under contract health services;

to Covered Persons who are Indians as defined in this Group Policy.

Indian Tribe means any Indian:

1. Tribe;
2. Band;
3. Nation; or
4. Other organized group or community, including:
    a. Any Alaska Native village; or
    b. Any regional or village corporation;

as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Injury means physical damage to the Covered Person's body, caused directly and independently of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

Inpatient or Inpatient Care means care and treatment provided to a Covered Person who has been admitted to a facility as a registered bed and who is receiving services, supplies and medications under the direction of a Participating Provider with staff and privileges at the facility. Such facilities include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes; or
5. Freestanding inpatient facilities.

Such facilities must be licensed or certified by the state in which it operates.

Investigational/Experimental Service means surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in Our judgment not recognized as conforming to accepted medical practice or the procedure, drug, or device:

1. Has not received the required final approval to market from appropriate government bodies; Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated to be as beneficial as established alternatives;
4. Has not been demonstrated to improve the net health outcomes; or
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Medically Necessary or **Medical Necessity** means treatment, services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a Covered Person's Illness, Injury, or medical condition according to accepted standards of medical practice.

Medical Necessary or Medical Necessity does not include treatment, services, medicines, or supplies that are:

1. Considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness;
2. Primarily for scholastic, vocational or developmental training;
3. Primarily for educational training, except for educational training services provided for Preventive Health Care Services or medical conditions as provided under this Group Policy. Preauthorization is required for all educational services;
4. Primarily for the comfort, convenience or administrative ease of the Physician or other health care provider, or the Covered Person or his or her family or caretaker; and
5. Custodial Care.

We reserve the right to review medical care and/or treatment plans. We may rely on Our independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician may order treatment does not, in itself, make it Medically Necessary, or make the expense a Covered Medical Expense.

Medical Group Policy means the utilization review management guidelines used for this Group Policy. The guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Package Fee means the cost benefit of “package” surgical services, which include: (1) the operation per se; (2) local infiltration; (3) metacarpal/digital block or topical anesthesia when used; and (4) normal, uncomplicated follow-up care. Normal, uncomplicated follow-up care would cover the period of Hospitalization and office follow-up for progress checks or any service directly related to the Surgical Procedure as per standard medical guidelines. The only exception would be if the service relates to Complications, exacerbations or recurrences of other diseases or Injuries requiring additional or separate services. When an additional Surgical Procedure(s) is carried out within the listed period of follow-up care for a previous Surgery, the follow-up periods will continue concurrently to their normal termination.

Group Policyowner means the person to whom this Group Policy is issued and is named as the Group Policyowner in the Schedule of Benefits. The Group Policyowner is the owner of this Group Policy, which means he or she may exercise the rights set forth in this Group Policy. On the Group

Policy Effective Date, the Group Policyowner is as designated in the application for this Group Policy. The Group Policyowner is also referred to as "You" or "Your".

Physician means a person licensed to practice medicine in the state where the service is provided. A Physician is a Participating Provider if he or she has an active contract with the HMO Network to provide services to Covered Persons under this Group Policy. A Physician is a Non-Participating Provider if he or she does not have an active contract with the HMO Network to provide services to Covered Persons under this Group Policy. The Covered Person should check to make sure that the Physician is a Participating Provider when seeking medical services.

Physician Specialist means a Physician who: (1) has obtained advanced training in various areas of a medical specialty; and (2) is board-certified in that specialty. Physician Specialist includes, but is not limited to: (1) Anesthesiologists; (2) Dermatologists; (3) Ophthalmologists; (4) Orthopedic Surgeons; (5) Psychiatrists; (6) Radiation Oncologist; and (7) Surgeons. Physician Specialist does not include: (1) a Family Practice Physician; (2) an Internal Medicine Physician; or (3) an obstetrician; or (4) gynecologist.

Services by a Physician Specialist is covered under this Group Policy if: (1) he or she is an active Participating Provider

Group Policy Effective Date means the date on which this Group Policy becomes effective. The Group Policy Effective Date is shown in the Schedule of Benefits.

Primary Care Physician means a provider who is:

1. Acting within the scope of his or her license; and
2. A Participating Provider.

A Primary Care Physician includes the following providers: (1) Family Practice (FP); (2) Internal Medicine (IM); (3) Pediatrician (MD); Obstetrics and Gynecology (OBGYN); (4) Gynecologist (GYN); (5) Geriatrician (MD); (6) Osteopath (DO); and (7) other providers performing services for Covered Persons in connection with the services provided by preceding specified providers, listed in (1) through (6), including: (a) Registered Nurse (RN); (b) Advanced Practical Registered Nurse (APRN); (c) Nurse Practitioner (NP); (d) Certified Nurse Midwife (CNM); and (e) Physician's Assistant (PA).

The following Participating Providers who are qualified and willing to provide primary care services as the Covered Person's Primary Care Physician may be elected by the Covered Person to be the Covered Person's Primary Care Physician:

1. An Obstetrician;
2. A Gynecologist; or
3. A Pediatrician.

Provider means a licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following Providers: (1) Medical Doctor (MD); (2) Chiropractor (DC); (3) Osteopath (DO); (4) Podiatrist (DPM); (5) Psychologist (PhD); (6) Licensed Clinical Social Worker (LCSW); (7) Psychiatric Nurse Specialist (RN, NS); (8) Doctor of Medical Dentistry (DMD); (9) Dentist (limited) (DDS); (10) Registered Nurse (RN); (11) Advanced Practical Registered Nurse (APRN); (12) Nurse Practitioner (NP); (13) Physician Assistant (PA); (14), Licensed Practical Nurse (LPN); (15) Certified Registered Nurse Anesthetist (CRNA); (16) Certified Nurse Midwife (CNM); (17) Registered Physical Therapist (RPT); (18) Occupational Therapist (OT); (19) Speech Therapist (ST); (20) Optometrist (limited[OD); (20) Audiologist, Licensed Professional Counselor (LPC); and (21) Registered Dietician.

The Provider is a Participating Provider only if the Provider is actively contracted as a Participating Provider with the HMO Network.

Outpatient means treatment or services that are provided when the Covered Person is not confined as a bed patient in a Covered Facility. This includes outpatient treatment at a Covered Facility as well as visits to a Physician or other Participating Providers.

Skilled Nursing Facility means an institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from Illness or Injury as an Inpatient, and:

1. Has organized facilities for medical treatment and provides 24-hour nursing service under the full time supervision of a Physician or a graduate registered nurse;
2. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;
3. Provides appropriate methods for dispensing and administering drugs and medicines; and
4. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider.

Any institution that is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism, is not considered a Skilled Nursing Facility.

Surgery or **Surgical Procedure** means manual procedures that: (a) involve cutting of body tissue; (b) debridement or permanent joining of body tissue for repair of wounds; (c) treatment of fractured bones or dislocated joints; (d) endoscopic procedures; (e) general anesthesia; (f) electocauterizing; (g) tapping (paracentesis); (h) applying plaster casts; (i) administering pneumothorax; or (j) endoscopy.

Treatment means medical care, services or treatment or course of treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

1. Confinement, Inpatient or Outpatient services or procedures; and
2. Drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Physician does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

SECTION 2: WHEN COVERAGE BEGINS AND ENDS

Your eligibility standards for Employees and their Dependents must be consistent with Health Insurance Marketplace rules.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Employees

If the Employee is an Eligible Employee, he or she will be eligible for coverage in accordance with the terms set forth in the group application.

The Eligible Employee must submit to the Group Policyholder: (1) a completed enrollment form; and (2) any premium contribution required for his or her coverage.

Dependents

The Dependents of an Eligible Employee may be enrolled for coverage under this Group Policy if:

1. The Dependent is an Eligible Dependent as defined under this Group Policy;
2. The Dependent is not covered under this Group Policy as an Employee; and
3. The Dependent is not on active duty in the armed forces;

If a child is an Eligible Dependent Child of more than one Covered Employee, the child may be covered for coverage under this Group Policy by only one Covered Employee at a time.

The Eligible Dependent must be included in the Covered Employee's enrollment form. The Policyholder will inform the Covered Employee of any premium contribution required for the Eligible Dependent's coverage.

If an Eligible Dependent is enrolled when the Eligible Employee enrolls for coverage under this Group Policy, the Effective Date of Coverage for the Eligible Dependent will be same as the Eligible Employee's Effective Date of Coverage.

When to Enroll New Dependents

If after the Covered Employee's Effective Date of Coverage, he or she acquires an Eligible Dependent as a result of:

1. Marriage or the establishment of a Domestic Partnership;
2. Birth;
3. Placement for adoption; or
4. Court or Administrative Order;

the Covered Employee may enroll the Eligible Dependent for coverage within the time periods indicated below in the *Adding a Dependent Due to Marriage/Domestic Partnership, Adding a Dependent Child Due to Birth or Placement for Adoption,* and *Adding a Dependent Due to Court or Administrative Order* provisions, subject to Exchange Rules if this Group Policy is purchased on the Exchange.

Adding a Dependent Due to Marriage/Domestic Partnership

If the Covered Employee acquires a new Dependent(s) due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the new Eligible Dependent(s) will be the first of the month following the date of the event, provided the Covered Employee gives the Group Policyholder a completed enrollment form for the new Eligible Dependent(s). The Group Policyholder will notify the Covered Employee if premium contribution is required for the new Eligible Dependent's coverage.

Adding a Dependent Child Due to Birth or Placement for Adoption

The Covered Employee must give the Group Policyholder a completed enrollment form to enroll a new Eligible Dependent Child when the Covered Employee acquires the new Eligible Dependent Child due to:

1. Birth; or
2. Placement for adoption.

The effective date of coverage for the new Eligible Dependent Child will be:

1. The date of birth for a newborn natural child;
2. The date of birth for newborn adopted child if placement for adoption occurs within thirty (30) days (or 60 days if this Group Policy was purchased on the exchange) of birth; and

3. The date of Placement for an adopted child, if Placement for adoption occurs thirty (30) days or more after the child's birth.

We must receive notification and any required premium for the new Eligible Dependent Child within 30 days (or 60 days of this Group Policy was purchased on the Exchange) in order for coverage to be continued under this Group Policy. If such notification and any required premium are not received by Us within the 30-day period (or 60-day period if this Group Policy was purchased on the Exchange), coverage under this Group Policy for the child only will be continued through the end of the month in which the notification and premium are due.

However, with regard to an adopted child, coverage under this Group Policy will cease prior to end of the 30-day period if:

1. The Placement is disrupted prior to legal adoption; and
2. The child is removed from Placement.

"Placement for adoption " or "Placement" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

Adding a Dependent Child Due to Court or Administrative Order

If a court or administrative order requires the Covered Employee to provide coverage for a Dependent Child, We must receive notification and any required premium for the child's coverage under this Group Policy within 30 days of the court or administrative order.

We will not deny coverage for the child on the grounds that the child:

1. Was born out of wedlock and is entitled to coverage as a noncustodial parent;
2. Was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;
3. Is not claimed as a dependent on the parent's federal tax return; or
4. Does not reside with the parent or in Our service area.

If the Covered Employee is required by a court or administrative support order to provide health insurance coverage for a child who resides outside of Our HMO Service Area, We will:

1. We will not deny coverage for the child for any of the reasons stated above in this provision;
2. Allow the Covered Employee parent to enroll the child for coverage under this Group Policy;
3. Pay for otherwise covered health care services rendered to the child outside of Our service area by a noncontracted Provider: (a) if the child, noncustodial parent, or custodial parent has complied with Prior Authorization or utilization review otherwise required by Us; and (b) in an amount equal to the dollar amount We pay under a noncapitated arrangement for comparable services to a contracting Provider in the same class of health care providers as the Provider who rendered the services;
4. Make payments on claims submitted in accordance with subparagraph 3., directly to the Provider, custodial parent, the child who obtained benefits, or state Medicaid agency.

The parents of the child who is the subject of the court or administrative support order are responsible for any charges billed by the Provider in excess of those paid by Us.

When Coverage Terminates

For Covered Employees

Coverage for the Covered Employee will terminate under this Group Policy on the last day of the month upon the occurrence of the following events:

1. The date the Covered Employee enters active duty in the military service. However, the Covered Employee may retain coverage for his or her Covered Dependents under this Group Policy if he or she notifies the Group Policyholder and pays any required premium for the continued coverage of the Covered Dependents;
2. The date of the Covered Employee's death;
3. The date the Covered Employee elects to terminate his or her coverage under this Group Policy; or
4. The date this Group Policy terminates.

Discontinuance of Coverage

We may discontinue coverage for the Covered Employee if:
1. The Covered Employee engages in act or practice that constitutes fraud in connection with his or her coverage under this Group Policy; or
2. The Covered Employee makes an intentional misrepresentation of material fact in connection with his or her coverage under this Group Policy.

If the Covered Employee's coverage is discontinued under this Group Policy, he or she may reenroll: (1) 12 months after the date of discontinuance; and (2) if this Group Policy is still in effect at the time the Eligible Employee applies to reenroll for coverage. Upon discontinuance of the Eligible Employee's coverage under this Group Policy, We will notify the Covered Employee of the right to enroll.

We may not discontinue coverage under this provision because of fraud or misrepresentation that relates to health status.

For Covered Dependents

Coverage for a Covered Dependent will continue in force under this Group Policy through the last day of the month in which he or she ceases to be a Covered Dependent. A Covered Dependent will cease to be a Covered Dependent under this Group Policy upon the occurrence of any of the following events:

1. The Covered Dependent no longer meets the eligibility requirements specified in this Group Policy;
2. The Covered Employee's spouse is no longer an eligible Dependent as a result of a divorce decree or legal separation;
3. The Covered Employee and his or her Domestic Partner are no longer in a Domestic Partnership relationship;
4. The Covered Dependent Child reaches his or her 26th birthday, except as provided for Handicapped Children;
5. The Covered Dependent enters active duty in the military;
6. The Covered Employee's death; or
7. This Group Policy terminates.

No coverage will be available for a Covered Dependent upon attainment of the limiting age for a Covered Benefit specifying a limiting age for coverage under this Group Policy.

Termination of Coverage for Handicapped Child

Coverage for a Covered Dependent Handicapped Child will continue in force under this Group Policy through the last day of the month in which he or she ceases to be a Covered Dependent. A

Covered Dependent Handicapped Child will cease to be a Covered Dependent under this Group Policy upon the occurrence of any of the following events:

1. The Dependent marries;
2. The Dependent obtains self-sustaining employment;
3. The Dependent ceases to be handicapped;
4. The Dependent ceases to be dependent upon the Covered Employee for support and maintenance;
5. If We do not receive written proof of the Dependent's handicap with 60 days of Our request for such proof;
6. The Covered Employee refuses to allow Us to examine the Dependent Child; or
7. We receive notification to terminate the Dependent's coverage under this Group Policy.

Suspension of Coverage During Military Service

If a Covered Person enters into active duty status for the military or naval service of the United States or any other country, coverage will be suspended as of the first date of active duty status. The Policyholder must notify Us of the Covered Person's active duty status within sixty (60) days of the first date of the Covered Person's active duty status; however, coverage will be suspended regardless of receipt of notification. When We receive notification of the active duty status, any required adjustment of premium will be made, including refund of premium if necessary.

Upon termination of active duty status, the Covered Person may request a resumption of coverage if the Covered Person:

1. Meets the eligibility requirements for Eligible Employee or Eligible Dependent as provided in this Group Policy;
2. Makes the request for resumption of coverage in writing within 180 days of the Covered Person's release from of active duty status; and
3. Pays any required premium for the Covered Person's coverage under this Group Policy.

Coverage under this Group Policy will resume on the date immediately following Our receipt and verification of the above requirements.

When May We Rescind this Group Policy?

If We find that You committed fraud or intentionally misrepresented material information on an application for this Group Policy within two (2) years from the Policy Effective Date of this Group Policy, this Group Policy will be rescinded and will be considered as never having been in effect, provided we give you 30 days prior notice. Any premiums paid will be refunded minus any claims paid for Covered Persons. We are entitled to recover the claim amounts that exceed the amount of premium paid.

When Can We Terminate this Group Policy?

We will terminate this Group Policy at 12:01 a.m. local time at Your place of business on the earliest of the following:

1. On any Group Policy Anniversary Date that this Group Policy is not renewed;
2. If You fail to pay the required premium payment when due, subject to the Grace Period; or
3. If You obtained this Group Policy through fraudulent means;
4. The date You terminate this Group Policy by giving us written notice at least 30 days in advance
5. For any other reason for termination of this Group Policy as specified in this Group Policy, provided We give You at least forty-five (45 days) prior written notice.

If this Group Policy was purchased on the Exchange, this Group Policy will be terminated by the Exchange rules.

What Is Our Responsibility for Payment of Claims if this Group Policy Terminates?

We will only pay eligible claims incurred by Covered Persons prior to the termination date of this Group Policy. We will not pay claims that are incurred after the date this Group Policy terminates for any reason.

Renewal of Group Policy

This Group Policy is renewable and continues in force at the option of the Policyholder. This Group Policy may be discontinued or nonrenewed if:

1. There is no longer any enrollee under this Group Policy who lives, resides, or works in:
   a. The service area of Our Network; or
   b. The area for which We are authorized to do business; and

2. If We no longer have the capacity to deliver services adequately to Covered Persons of the Policyholder and uniformly to all such policyholders to which provide coverage. Such nonrenewable will not be based on: (a) the claims experience of an employer, an employer's employee, or a dependent of an employee; or (b) any health status-related factor relating to an employee or dependent of an employee.
3. A condition described in subparagraph numbers 1 and 2 above exists;
4. You fail to pay premiums or contributions in accordance with the terms of this Group Policy;
5. You perform an act or practice that constitutes fraud;
6. You make an intentional misrepresentation of material fact under the terms of this Group Policy;
7. We elect to discontinue offering this Group Policy benefit product delivered or issued for delivery in the state of Utah. In this event, We will:

   a. Provide notice of the discontinuation in writing: (1) to each policyholder (plan sponsor), covered employee, and covered dependent of the policyholder (plan sponsor) or employee; and (2) at least 90 days before the date the coverage will be discontinued.
   b. Provide notice of the discontinuation in writing: (1) to the Utah Commissioner of Insurance; and (2) at least three working days prior to the date the notice is sent to the affected policyholders (plan sponsors), employees, and dependents of policyholders (plan sponsors) or employees.
   c. Offer to each policyholder (plan sponsor), on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered: (1) by Us in the small group market; (2) in the case of a large employer, any other health benefit plan currently being offered in that market; and
   d. In exercising the option to discontinue that product and in offering the option of coverage in this provision, We act uniformly without regard to: (1) the claims experience of the policyholder (plan sponsor); (2) any health status-related factor relating to any covered person or beneficiary; or (3) any health status-related factor relating to a new covered person or beneficiary who may become eligible for coverage; or
   e. We: (1) elect to discontinue all of Our health benefit plans: (A) in the small employer market; or (B) the large employer market; or (C) both the small and large employer markets; and
   f. We: (1) provide notice of the discontinuance in writing: (A) to each policyholder (plan sponsor), employee, or dependent of a policyholder (plan sponsor) or an employee; and (B) at least 180 days before the date the coverage will be discontinued; and (2) provide notice of the discontinuation in writing: (A) to the commissioner in each state in which an affected insured individual is known to reside; and (B) at least 30 business days prior to the date the notice is sent to the affected policyholders (plan sponsors), employees, and dependents of a policyholder (plan sponsor) or employee; and (3)

discontinue and nonrenew all plans issued or delivered for issuance in the small group market; and (4) provides a plan of orderly withdrawal as required by Utah state insurance law.

8. We may discontinue or nonrenew a large employer health benefit plan: (a) if a condition described in subparagraph number 2., above exists; or (b) for noncompliance with: (1) Our minimum participation requirements; or (2)) employer contribution requirements.
9. We may discontinue or nonrenew a small employer health benefit plan: (a) if a condition described in subparagraph number 2., above exists; or (b) for noncompliance with Our employer contribution requirements.
10. We may nonrenew a small employer health benefit plan: (a) if a condition described in subparagraph number 2. above exists; or (b) for noncompliance with Our minimum participation requirements.

CONTINUED COVERAGE

Continued Coverage for Former Spouse

If the coverage for the Covered Employee's Covered Dependent spouse is terminated under this Group Policy due to divorce or the Covered Employee's death, the spouse will be entitled upon application and payment of the appropriate premium to have issued to him or her an individual Policy upon entry of the divorce decree or annulment or upon the date of the Covered Employee's death. The individual policy that will be issued will provide the most nearly similar to the terminated coverage as provided under this Group Policy.

When We receive the actual notice that the Covered Dependent spouse is to be terminated because of a divorce or annulment or death of the Covered Employee, We will promptly provide the spouse written notification of: (1) the right to obtain an individual Group Policy; (2) the premium amounts required; and (3) the manner, place, and time in which premiums may be paid. The spouse may include coverage for the Covered Employee's Covered Dependent Children insured under this Group Policy.

The premium for the individual policy will be determined in accordance with Our table of premium rates applicable to: (1) the age of the spouse; and (2) the type and amount of coverage provided. If the spouse applies for the individual policy and submits the first monthly premium to Us within 30 days after receiving the written notification regarding the individual policy, We will issue the spouse with the individual policy which will be effective immediately upon termination of his or her coverage under this Group Policy.

COBRA CONTINUATION OF COVERAGE

If this Group Policy remains in effect, but the Covered Employee's or a Covered Dependent's coverage under this Group Policy would otherwise terminate, We may be required to offer such Covered Employee or Covered Dependent the right to continue coverage under this Group Policy. This right is referred to as "Continuation Coverage" and may occur for a limited time subject to the terms of this provision and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA only applies to this Group Policy if the Policyholder covers at least 20 Eligible Employees under this Group Policy.

Eligibility

If Covered Employee or Covered Dependent has been covered under this Group Policy on the day before a qualifying event, the Covered Employee or Covered Dependent may be eligible for COBRA Continuation Coverage. The following are qualifying events for such COBRA Continuation Coverage if, under the terms of this Group Policy, the event causes the Covered Employee or Covered Dependent to lose coverage:

1. For Covered [Employees] , loss of coverage because of:

    a. The termination of employment except for gross misconduct; or
    b. A reduction in the number of hours worked by the Covered Employee.

2. For Covered Dependents, loss of coverage because of:

    a. The termination of the Covered Employee's coverage under this Group Policy'
    b. The death of the Covered Employee;
    c. The divorce or legal separation from the Covered Employee;
    d. The Covered Employee becomes entitled to Medicare, if applicable; or
    e. The Covered Dependent reaches the limiting age for coverage under this Group Policy.

Enrolling for COBRA Continuation Coverage

We will provide notification of the rights to enroll for COBRA Continuation Coverage to the Covered Employee or Covered Dependent after:

1. The Covered Employees termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or
2. The Covered Employee or Covered Dependent notifies Us, in writing, within 60 days after any other qualifying event set out above in this COBRA Continuation Coverage provision

The Covered Employee or Covered Dependent has 60 days from the later of the date of:

1. The qualifying event; or
2. The date that the Covered Employee or Covered Dependent receives notice of the right to COBRA Continuation Coverage to enroll for such Coverage.

We will send the Covered Employee or Covered Dependent the necessary forms that should be used to enroll for COBRA Continuation Coverage. If the Covered Employee or Covered Dependent does not send the written notification form to Us within the 60-day period, the Covered Employee or Covered Dependent will lose their right to COBRA Continuation Coverage. If the Covered Employee or Covered Dependent qualifies for COBRA Continuation Coverage and receives services that would be for Covered Benefits, before enrolling and paying the premium for COBRA Continuation Coverage, the Covered Employee or Covered Dependent will be required to pay for those services. We will reimburse the Covered Employee or Covered Dependent for Covered

Medical Expenses incurred for Covered Benefits, less required cost-sharing or other any payments required by to be paid by the Covered Employee or Covered Dependent, after the Covered Employee or Covered Dependent enrolls and pay the required premium for the COBRA Continuation Coverage, and submit a claim for those Covered Medical Expenses incurred for the Covered Benefits provided under this Group Policy.

SECTION 3 – PREMIUMS

When are Premiums Due?

All premium, any charges or fees for this Group Policy (hereinafter referred to as "premium") must be paid to Us by You. The premium due under this Group Policy on each Premium Due Date will be the sum of the premium charges for the insurance provided under this Group Policy. It is Your responsibility to collect any premium contributions required by Covered Employees for their coverage under this Group Policy. If You do not pay premiums when due, this Group Policy will terminate subject to the *Grace Period*. The Premium Due Date is shown on the cover page of this Group Policy.

Grace Period

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. Coverage under this Group Policy will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, this Group Policy will automatically terminate at the end of the Grace Period. If this Group Policy was purchased on the Exchange, this Grace Period provision will be subject to any Exchange rules governing the grace period for payment of premiums.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state of Utah, where this Group Policy is issued, We may change the rates for this Group Policy on any Policy Anniversary Date. We will give You at least 45 days advance written notice prior to the effective date of any rate change.

SECTION 4 – HOW HMO COVERAGE WORKS

Some plans are identified as HMO plans. Except for Emergency Services and Urgent Care Services, no benefits are provided Out-of-Network. All services must be provided in the HMO Network in order for benefits to be payable under this policy. Refer to your plan summary or schedule of benefit to determine if your plan is an HMO or has out of network coverage.

What are the Responsibilities of the Covered Person for Participating Providers?

The Covered Person is responsible for making sure that providers and facilities, at the time of service, are Participating Providers in the HMO Network. Services will not be paid for services rendered by providers or facilities that, at the time of service, are not Participating Providers in the HMO Network. This exclusion does not apply to: (1) Emergency Services provided in a Hospital Emergency Room facility or an Urgent Care Facility; (2) out-of-area urgent care; or (3) providers or facilities that We have authorized at least 24 hours in advance to render services.

SECTION 5 – COVERED BENEFITS

The following Covered Benefits are insured under this Group Policy. Covered Medical Expenses incurred for Covered Benefits will be paid when the Covered Person receives services from his or her Participating Provider. Covered Benefits are subject to the applicable exclusions and limitations specified in this Section 6 and in Section 9.

Payment of Benefits

Payment of Covered Medical Expenses will be:

1. Based on the Maximum Allowable Fee; and
2. Subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum stated in the Schedule of Benefits, unless otherwise stated in the Schedule of Benefits or this Section for specified Covered Benefits.

Exceptions

However, if such Covered Person receives services for Covered Benefits from a Participating Provider of the HMO Network, this Group Policy will pay benefits on an In-Network basis and the Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will

apply.

Benefits Paid Without Cost-Sharing Requirements for Certain Covered Persons Who Are Indians

The Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will not apply to a Covered Person who is an Indian, as defined in this Group Policy, and who:

1. Meets the specific federal government guidelines to exempt such Covered Person from the cost-sharing requirements of this Group Policy; and
2. Obtains services from either an In-Network Providers or Out-of-Network Providers.

Benefits Eligible for Payment

Benefits will be eligible for payment if Covered Medical Expenses are:

1. Incurred for Covered Benefits while the Covered Person is insured under this Group Policy; and
2. The Treatment for which the Covered Medical Expenses are incurred is:
   a. The result of an Illness or Injury; and
   b. Medically Necessary, unless the Covered Benefit is for educational purposes only, as provided under this Group Policy; or
   c. Prescribed or treated by the Covered Person's Participating Provider as provided in this Group Policy.

Covered Benefits provided under this Group Policy are subject to the exclusions, limitations and all terms and conditions specified in this Group Policy in Section 6.

Adoption Indemnity Benefit

Coverage is provided for an Adoption Indemnity Benefit which is to assist the Covered Employee with legal or agency fees in the adoption of a child. The Adoption Indemnity Benefit will be payable to the Covered Employee on the date of the adoptive placement of the child with the Covered Employee. The adoptive placement must take place within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the Covered Employee, only one Adoption Indemnity Benefit will be paid.

The maximum benefit payable for the Adoption Indemnity Benefit is shown in the Schedule of Benefits and is subject to the same deductible, coinsurance, and/or copayments normally applied to Maternity Care services., subject to any adjustments permitted by law. However, We only will pay Our pro rata share of the Adoption Indemnity Benefit, if each adoptive parent:

1. Has coverage for maternity benefits with a different insurer; and
2. Makes a claim for the Adoption Indemnity Benefit.

To be eligible for this benefit: the Covered Employee must be: (1) one of the adoptive parents, or (2) the adoptive parent.

If We pay the Adoption Indemnity Benefit, We may seek reimbursement of the benefit if:

1. The postplacement evaluation disapproves the adoption placement; and
2. A court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

Exclusions

No benefits will be payable for:

1. All of the following: (a) transportation; (b) travel expenses or accommodations; (c) passport fees; (d) translation fees; (e) photos; and (f) postage etc.
2. Living expenses, food, and/or counseling for the birth mother.

Ambulance Benefits

Coverage is provided for eligible ground and air ambulance services when: (1) due to an Emergency Medical Condition; and (2) Medically Necessary.

1. Air Ambulance Services: Air Ambulance Services must be provided by a licensed professional air ambulance company to transport the Covered Person;
   a. To or from the nearest Hospital where appropriate facilities and staff are available to care and treat the Emergency Medical Condition of the Covered Person; or
   b. Between medical facilities for treatment of the Emergency Medical Condition.
2. Air Ambulance is limited to Life-threatening emergencies when the Covered Person could not be safely transported by ground ambulance. Ground Ambulance Services: Ground Ambulance Services must be provided by a licensed professional ambulance company to transport the Covered Person by ground:
   a. To or from the nearest Hospital where appropriate facilities and staff are available to care and treat the Emergency Medical Condition of the Covered Person; or
   b. Between medical facilities for treatment of the Emergency Medical Condition.

Exclusions

No benefits will be payable for:

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.
3. After-hours charges.
4. Charges for ambulance waiting time.

Anesthesia Benefits

The charges for Medically Necessary anesthesia administered by a Participating Provider who is an Anesthesiologist (M.D. or D.O.) or a Certified Registered Nurse Anesthetist (CRNA) in conjunction with Medically Necessary Surgery. The benefit is payable as shown in the Schedule of Benefits.

Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. However, the following exceptions apply:

1. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
2. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.
3. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.
4. Moderate sedation (conscious sedation) is included in standard colonoscopy and EGD surgery and will not be reimbursed separately.

E*xclusions*

The following services in connection with this Anesthesia Benefit are excluded from coverage, and will not be paid:

1. Anesthesia in conjunction with ineligible Surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care or on-call time for consultant.

4. Additional charges for supplies, drugs, equipment, etc.

Breast Surgery, Reconstruction and Prostheses Benefit

If the Covered Person has a mastectomy, coverage will be provided, with consultation of the attending Participating Provider and the Covered Person, for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and
3. Prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

We will provide notice of the availability of this coverage upon Group Policy issuance and annually thereafter.

Diagnostic Testing, Lab and X-ray Benefit

Coverage is provided for Medically Necessary:

1. Laboratory;
2. X-ray;
3. Computed Tomography Scan (CT Scan);
4. Magnetic Resonance Imaging (MRI);
5. Magnetic Resonance Angiogram (MRA); and
6. Ultrasound services are payable.

A fee for transportation of x-ray equipment is payable when appropriate.

Lab and x-ray in conjunction with office Surgery are payable under the Surgical Benefit.

Limitations

1. Lab and x-rays are only eligible for diagnosing or treating symptomatic Illness and must be specific to the potential diagnosis.
2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Covered Person and the transplant is eligible.

Refer to *Section 9, Limitations and Exclusions*, for excluded services.

Dietary Products for Hereditary Metabolic Disorder

Coverage is provided for specific formulated products for the treatment of error of amino acid or urea cycle metabolism, while under the direction and supervision of a Participating Provider. Such products will include:

1. Medical foods;
2. Metabolic supplements; and
3. Gastric Disorder Formula;

as prescribed by a Participating Provider. Preauthotization is required for Medical Foods, Metabolic Supplements, and Gastric Disorder Formula.

The following are not considered medically appropriate and are not covered as a Metabolic Food/ Metabolic Supplement and Gastric Disorder Formula benefit:

1. Standard oral infant formula;
2. Food thickeners, baby food, or other regular grocery products;
3. Nutrition for a diagnosis of anorexia; and
4. Nutrition for nausea associated with mood disorder, end-stage disease, etc.

“Inherited Metabolic Disorder” means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as may be prescribed by state law.

“Medical Foods” means modified low protein foods and metabolic formula.

“Metabolic Formula” means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a Participating Provider who is a medical doctor or doctor of osteopathy;
2. Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs;
3. Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
4. Essential to a person’s optimal growth, health and metabolic homeostasis.

“Modified Low Protein Foods” means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a Participating Provider who is a medical doctor or doctor of osteopathy.
2. Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein;
3. Administered for the medical and nutritional management of the Covered Person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and
4. Essential to a person’s optimal growth, health and metabolic homeostasis.

Durable Medical Equipment/Supply Benefit

All Durable Medical Equipment/Supply Benefit over $500 requires preauthorization. Coverage is provided for durable medical equipment and supplies when the equipment or supplies are: is:

1. Medically Necessary;
2. Prescribed by a Participating Provider and approved by Us; and
3. Used for medical purposes rather than for convenience or comfort.

Benefits will be payable for the cost of standard conventional equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies will be the responsibility of the Covered Person.

The total benefits allowable for rental and/or subsequent purchase may not exceed 100% of the allowable purchase price of the equipment.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Emergency Services

Coverage is provided for a Medically Necessary Emergency Medical Condition provided in a

Hospital Emergency Department. Each follow-up visit in the Hospital Emergency Department will require an additional emergency room Deductible, if applicable as shown in the Schedule of Benefits. When emergency room treatment results in an Inpatient Hospital admission (within 24 hours), benefits are payable as an Inpatient Hospital Stay.

Emergency Services coverage includes any covered: (1) evaluation; (2) diagnostic tests; or (3) other covered treatment considered Medically Necessary to stabilize the Emergency Medical Condition of the Covered Person.

Benefits for Emergency Services will be eligible for payment when the services are provided in a Participating Facility.

However, Emergency Services provided at a Non-Participating Facility will require Authorization after the Covered Person's Emergency Medical Condition is stabilized. The use of a Non-Participating Facility will be eligible for payment if:

1. It is the nearest facility for the care and treatment of the Covered Person's Emergency Medical Condition; and
2. The Covered Person's Emergency Medical Condition is life-threatening.

"Hospital Emergency Department" means that area of a Hospital in which emergency services are provided on a 24-hour-a-day basis.

Foot Care by Podiatrists

Coverage is provided for Medically Necessary foot care services provided by a Participating Provider Podiatrist only when prescribed by the Primary Care Physician for the treatment of a vascular or metabolic condition. Medically necessary foot care includes the cutting or removal of corns and calluses; trimming, cutting, clipping, or debriding of nails; and other hygienic care due to a physical or clinical finding that is consistent with a metabolic and/or vascular disease diagnosis. Services may be provided by a Podiatrist.

No benefits will be payable under this provision for foot care that is not Medically Necessary. Preauthorization is required.

Home Health Care and Hospice Care Services Benefit

Coverage is provided for:

1. Skilled Home Health Care Services;
2. Home IV Therapy; and
3. Hospice Care Services;

when such services are Preauthorized and Medically Necessary.

Home Health Care Services

Coverage is provided for Home Health Care Services limited to the Maximum Number of visits per Policy year as shown in the Schedule of Benefits. Benefits are eligible for payment the following criteria are met:

1. The Primary Care Physician must have determined a medical need for home health care and developed a plan of care that is reviewed at thirty-day intervals by the Primary Care Physician.
2. The care described in the plan of care must be for: (a) intermittent skilled nursing; (b) therapy; or (c) speech services.

3. The Covered Person must be homebound unless services are determined to be Medically Necessary by the Utilization Review Management Organization.
4. The home health agency delivering care must be certified within the state where the care is received.
5. The care that is being provided is not custodial care.

A Home Health visit/day is considered to be up to four (4) hours of services. Home health services do not include services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's home. If physical therapy, occupational therapy, and speech therapy are provided in the home, the number of therapy visits will be subject to the Maximum Number of visits per Policy year, if any, as shown in the Schedule of Benefits or such therapies will be based on the plan of care prescribed by the Participating Physician.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Hospice Care Services

Hospice benefits may be approved when the Covered Person is:

1. Terminally Ill;
2. No longer receiving any curative treatment, and
3. Only receiving palliative care for pain relief, symptom control and comfort.

Coverage is provided for hospice care services when provided:

1. Under an approved hospice care program; and
2. To a Covered Person who has been diagnosed by a Participating Provider as having a terminal illness.

Hospice care services include: (1) Inpatient care; (2) Outpatient services; (3) professional services of a Physician; (4) services of: (a) a psychologist; (b) social worker or family counselor for individual and family counseling; and (c) home health services.

Hospice care services do not include the following:

1. Services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's house;
2. Services and supplies for curative or life prolonging procedures;
3. Services and supplies for which any other benefits are payable under this Group Policy;
4. Services and supplies that are primarily to aid the Covered Person in daily living;
5. Services and supplies for respite (custodial) care; and
6. Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by:

1. A Participating Hospital;
2. A Participating skilled nursing facility or a similar institution;
3. A Participating home health care agency;
4. A Participating hospice facility, or any other licensed facility or agency under a Medicare-approved hospice care program.

A hospice care program is:

1. A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;

2. A program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and
3. A program for persons who have a terminal illness and for the families of those persons.

A hospice facility:

1. Is a Participating institution or portion of a facility which primarily provides care for terminally ill patients;
2. Is a Medicare-approved hospice care facility;
3. Meets standards established by this Group Policy; and
4. Fulfills all licensing requirements of the state or locality in which it operates.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

In-Hospital Services

Coverage is provided for Medically Necessary Inpatient Hospitalization (semi-private room, ICU, and eligible ancillaries). Inpatient Hospitalization services include:

1. Semi-private room;
2. Intensive Care Unit (ICU); and
3. Eligible ancillaries.

Hospital admissions require Pre-notification to the Utilization Review Management Program. See Section 7.

When a Hospital Stay that begins in one Policy year and spans to a new Policy year, charges billed on the Hospital claim will be based on the benefit provisions in effect during the Policy year in which the Hospital stay began

Eligible ancillary services, including but not limited to:

1. Inpatient Physician visits;
2. Diagnostic tests;
3. Laboratory tests;

which are performed during the Hospital Stay but billed separately from the Hospital will apply to the benefits in effect under the Policy year on the actual date of service billed.

Maternity Care Services

Coverage is provided for Maternity care services including medical, surgical and hospital care: (1) during the term of pregnancy; (2) upon delivery and during the postpartum period for normal delivery; (3) cesarean section; (4) spontaneous abortion (miscarriage); (5) complications of pregnancy; and (6) maternal risk.

Coverage for a mother and her newly born child will be available for:

1. A minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery; and
2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section.

Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These benefits do not apply to the newly born child of a Covered Dependent daughter unless placement with You is confirmed through a court order or legal guardianship.

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Covered Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under Federal law, Covered Physicians are not required to obtain Preauthorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prenatal and Postnatal Care. Office visits for prenatal and postnatal care are covered if services are obtained by Participating Provider.

Medical Visit Benefit

Coverage is provided for Medically Necessary medical visits, including visits:

1. In the Participating Provider's office;
2. Urgent Care Facility;
3. Emergency room;
4. Hospital; or
5. The Covered Person's home;

Coverage also is provided for other Outpatient or office services including but not limited to: (1) chemotherapy; (2) office Surgery; and (3) labs and x-rays; (4) blood "factor" replacement.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Mental Health Benefit – Mental Illness and Substance Abuse Coverage

Coverage is provided this Mental Health Benefit for Mental Illness and Substance Abuse under this Group Policy. All services provided for Mental Illness and Substance Abuse must be Preauthorized.
Facility and Hospital Services

Coverage is provided for Medically Necessary services rendered in the following Participating facilities:
1. Hospitals;
2. Inpatient treatment centers);
3. Inpatient pain clinics;
4. Day treatment facilities; or
5. Intensive outpatient programs.

Preauthorization must be obtained for these services. Failure to obtain Preauthorization will result in denial of benefits. Charges for a full Hospital stay will be: (1) prorated into a per diem rate; or (2) as provided in the Participating Providers contracts of specific Providers, for adjudication of daily benefits. Day treatment or intensive Outpatient program may be considered in lieu of Inpatient care with two or more days applicable to one Inpatient day based on Participating Provider agreements or Preauthorization. If program is not completed, benefits revert to outpatient coverage.

Electro Convulsive Therapy is eligible under the Medical Services Benefit.

Eating disorders, such as anorexia and/or bulimia, are payable as a medical benefit while Life-threatening, as determined by Our Utilization Review Management Program. When the condition is

no longer Life-threatening, benefits are payable under Mental Health and require Preauthorization.

Inpatient Provider Visits

Coverage is provided for Hospital visits by the Participating Provider.

Outpatient Provider Visits

Outpatient treatment visits for Mental Health or Substance Abuse are eligible for coverage when provided by: (1) a licensed psychologist; (b) licensed clinical social worker; (c) medical Provider; or (d) licensed psychiatric nurse specialist is eligible. All such Providers must be Participating Providers.

Eligible neuropsychological evaluations and testing are payable as a medical benefit.
Eligible medical management to monitor use of psychotropic drugs will be covered as a medical benefit.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Obstetrical/Gynecological Visits

Coverage will be provided for female Covered Persons to receive an Outpatient examination by a Participating Provider who is an Obstetrician/Gynecologist and a member of the American College of Obstetrics and Gynecology. No Preauthorization or referral is required for such visit.

Outpatient Facility Benefits

Coverage is provided for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based.

Pediatric Services

Coverage will be provided for Pediatric preventive care services for Covered Dependent Children under age eighteen (18). Benefits include, but are not limited to: (1) appropriate immunizations as defined by Standards of Child Health Care issued by the American Academy of Pediatrics or other guidelines required by the state; (2) developmental assessments, which includes Physician visits for child health supervision services; (3) laboratory services; and (4) any other care and services mandated by the federal Affordable Care Act.

Pediatric Vision Care Program

Coverage will be provided for vision care services for Covered Dependent Children under age 19. Vision Care services and the vision care Participating Provider Network used for this benefit are administered by VSP as shown on page 2, *Important Information*. A directory listing of the VSP Participating Providers can be obtained from the VSP website, or The Covered Employee contact VSP by telephone or mail; the VSP contact information is shown on page 2. This vision benefit does not require a referral from the Covered Person's Primary Care Physician.

Benefits will be provided for the covered services shown in the Schedule of Benefits for the stated frequency of services. The frequency of service for each covered service is once every 12 months, unless otherwise stated in the Schedule of Benefits.

The Covered Person may choose either eyeglasses or contact lenses during any Policy year; however, no benefits will be provided for both eyeglasses and contact lenses during the same Policy year period. Benefits payable under this Pediatric Vision Care Program benefit are subject to the terms, conditions, exclusions, limitations outlined in this Covered Benefit and this Group

Policy.

Eye Examinations

Benefits will be provided for one eye examination for each eligible Covered Dependent Child during the Policy year. The eye examination may be for one of the following: (1) eyeglasses; (2) contact lenses; or (3) for both eyeglasses and contact lenses during one examination. No benefits will be payable for another eye examination performed during the Policy year. No benefits will be payable for separate eye examinations for eyeglasses and contact lenses during the Policy year.

Vision Care Materials: Eyeglass Lenses, Coatings, and Frames

Benefits will be provided for eyeglass lenses, eyeglass coatings, and eyeglass frames as shown in the Schedule of Benefits.

The frame selection covered under this Vision Care benefit will be from a Pediatric Collection at the Physician's office.

Contact Lenses

In lieu of eyeglasses, the Covered Person may elect to receive Vision Care Materials for contact lenses as shown in the Schedule of Benefits. Either eyeglasses or contact lenses may be elected during the Policy year, but not both.

Benefits are payable for Necessary Contact Lenses for Covered Persons who have specific conditions for which contact lenses provide better visual correction. The Necessary Contact Lenses must be recommended and prescribed by the Vision Physician.

The following service limitations apply to In-Network benefits for Contact Lenses:

1. Standard (one pair of contact lenses per Policy year): Benefits are limited to one (1) contact lens per eye (total 2 lenses);
2. Monthly (six-month supply): Benefits are limited to six (6) disposable lenses per eye (total 12 lenses);
3. Bi-weekly (3 month supply): Benefits are limited to six (6) disposable lenses per eye (total 12 lenses); and
4. Dailies (one month supply): Benefits are limited to thirty (30) disposable lenses per eye (total 60 lenses.

The following items are not covered under this contact lens benefit provision:

1. Other insurance policies or service agreements;
2. Artistically painted or non-prescription lenses;
3. Additional office visits for contact lens pathology;
4. Contact lens modification, polishing or cleaning; and
5. Orthoptics, vision training, supplemental testing.

Payment of Benefits

Benefits will be paid as shown in the Schedule of Benefits.

When services are received from a Participating Provider, the benefits are fully covered at no cost to the Covered Person. Therefore, no claims have to be submitted to Us or VSP. The Participating Provider will not require payment for the Vision Care services provided to the Covered Dependent Child.

When services are received from a Non-Participating Provider, the Covered Employee will be responsible for paying the difference between the benefit payable under this Vision Care benefit and the amount billed by the Non-Participating Provider. The Covered Employee will have to submit a claim to VSP to obtain reimbursement for any amount the Covered Employee pay that is covered under this Vision Care benefit.

Claims and Appeals for Denied Claims

VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Denial of Preauthorization Requests. If VSP denies the Physician's request for Preauthorization, the Physician, the Covered Employee or the Covered Employee's authorized representative may request an appeal the denial. Please refer to the "Claim Appeals" provision below, for details on how to request an appeal. VSP will provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP will resolve any second level appeal within thirty (30) calendar days. The Covered Employee may designate any person, including the provider, as his or her authorized representative.

Request for Appeals: If the Covered Dependent Child's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Employee in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, the Covered Employee may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Employee and the Covered Dependent Child for whom a claim for benefits was denied, including the Covered Employee's VSP Member Identification Number, the Covered Dependent Child's name and date of birth, the name of the provider of services and the claim number. The Covered Employee may state the reasons he or she believes that the claim denial was in error. The Covered Employee may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Employee the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The Covered Employee or his or her authorized representative should submit all requests for appeals to VSP.

VSP contact information for claims is shown on page 2, *Important Information*.

Exclusions and Limitations

The following exclusions and limitations apply only to this Pediatric Vision Care benefit. No coverage will be provided under this Vision Care benefit for:

1. The purchase of two pairs of glasses instead of bifocals. Only one pair of glasses are payable under this Vision Care benefit per Policy year.
2. Medical or surgical treatment.
3. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power.
4. Replacement of lenses and frames furnished under This Plan which are lost or broken except at the normal intervals when services are otherwise available.
5. Corrective vision treatment of an Experimental Nature.
6. Costs for services and/or materials above the benefits payable for the Covered Vision Care services.
7. Services or materials not indicated as Covered Vision Care benefit.

Physician Services

Coverage is provided for Physician services provided by the Primary Care Physician or other Participating Provider, including Participating Providers who are specialist. Physician Services include office visits, In-Hospital visits, and surgeries.

Prescription Drugs Benefit

Generic and Brand-Named Prescription Drugs are covered under this Group Policy, as provided in this Covered Benefit provision. All Prescription Drugs must be prescribed by a Participating Provider Physician.

Covered Prescription Drugs are provided in the Prescription Drug Formulary for this Group Policy. The Prescription Drug Formulary will be provided to You with this Group Policy issuance and with all Certificates issued under this Group Policy. The formulary also may be obtained on Our website or by calling the Customer Service number appearing on page 2, Important Information. Prescription Drugs may be obtained from a Participating Pharmacy (retail) or Participating Mail Order Pharmacy only; no coverage is provided for prescription drugs obtained from a Non-Participating Pharmacy (retail) or Non-Participating Mail Order Pharmacy. The Participating Pharmacy and Participating Mail Order Pharmacy directory listing also may be obtained on Our website or by calling the Customer Service number appearing on page 2, Important Information.

Drug Formulary, Preauthorization, and Prescription Drug Supply Limits

The Prescription Drugs provided under this Group Policy are based on the Drug Formulary for this Group Policy. Therefore, only those prescription drugs listed in the Drug Formulary for this Group Policy will be covered under this Group Policy.

Prescription Drugs that require Preauthorization are listed in the Drug Formulary. If the Covered Person does not obtain Preauthorization for a Prescription Drug listed in the Prescription Drug Preauthorization List, the Covered Person must submit a claim with supporting documentation to Our Customer Service address, which is shown on page 2, for reimbursement considerations.

Prescription Drugs will be dispensed as follows:

1. Per prescription or refill at a retail Participating Pharmacy is limited to a maximum of a 30-day supply based on the FDA-approved dosage regardless of the manufacturer packaging; and

2. Per prescription or refill received from the Participating Mail Order Pharmacy is limited to a maximum of a 90-day supply based on the FDA-approved dosage regardless of the manufacturer packaging. However, Self-Administered Injectable Drugs are limited to a maximum of a 30-day supply per prescription or refill received from the Participating Mail Order Pharmacy.

If Prescription Drugs are purchased at a retail Participating Provider Pharmacy, the Covered Person may present his or her Identification Card (ID) at the time of purchase and pay the required Prescription Drug Deductible and/or Copayment as shown in the Schedule of Benefits or pay for the Drug and then submit claim paperwork for manual reimbursement , provided the Drug is on the formulary.

If Prescription Drugs are purchased through the Participating Mail Order Pharmacy, the Covered Person must provide the Participating Mail Order Pharmacy with the completed order form,

Deductible and/or Copayment amount as shown in the Schedule of Benefits, and the signed Physician prescription.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Preventive Health Care Services Benefit

Preventive Health Care Services for health care screenings or preventive purposes submitted with a routine diagnosis will be covered at 100% of the Maximum Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of-Pocket Maximum when services are provided by a Participating Provider. Preventive Health Care Services must be provided by Participating Providers. Preventive Health Care Services will be provided in accordance with the Affordable Care Act.

Educational training for Preventive Health Care Services that is necessary and prescribed by a Participating Provider Physician will be covered.

The following are some of the services provided under this Preventive Health Care Services Benefit. Coverage will be provided in accordance with the requirements of the federal Affordable Care Act:

1. **Blood Pressure Screening.**

2. **Cancer Screenings.** Coverage for cancer screenings includes, but is not limited to: (a) Breast Cancer Screenings (Mammograms); (b) Colorectal Cancer Screenings; (c) Prostate Cancer Screenings; and (d) any other cancer screenings required by the federal Affordable Care Act.

3. **Cholesterol Tests.**

4. **Counseling Services.** Coverage for counseling will be provided on such topics as: (a) quitting smoking; (b) losing weight; (c) eating healthfully; (d) treating depression; (e) reducing alcohol use; and (f) any other counseling services mandated by the federal Affordable Care Act.

5. **Diabetes Management and Supplies.** Coverage will be provided for Diabetes Self-Management, Equipment and Supplies when deemed Medically Necessary. Benefits include outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a Participating Provider with expertise in diabetes. The following services will be provided unless the federal Affordable Care Act provides differently. The benefits that will be provided for Diabetes Self-Management and Supplies will be in accordance with the benefits required by the federal Affordable Care Act.

   The diabetes self-management training services must be provided by a diabetes self-management training program that is accepted by the plan and is:

   a. Recognized by the federal Health Care Financing Administration; or
   b. Certified by the Department of Health; or
   c. Approved or accredited by a national organization certifying standards of quality in the provision of diabetes self-management education.

   Diabetes self-management training programs must be provided upon: (a) the Participating Provider's diagnosis with diabetes; (b) a significant change in the Covered Person's diabetes related condition;(c) a change in the Covered Person's diagnostic levels; or (d) a change in treatment regimen when deemed Medically Necessary and prescribed by an attending Physician who is a Participating Provider. We will provide no less than the minimum standards required by the selected self-management training services provider program.

The following will be covered under preventive care when deemed Medically Necessary and found under the Preferred Tier 1 and Tier 2 pharmacy formulary list:

a. Preferred blood glucose monitors, including commercially available blood glucose monitors designed for patients use and for persons who have been diagnosed with diabetes;
b. Preferred blood glucose monitors to the legally blind which includes commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
c. Preferred test strips for glucose monitors, which include test strips whose performance achieved clearance by the FDA for marketing;
d. Preferred visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Using urine test strips for glucose only is not acceptable as the sole method of monitoring blood sugar levels;
e. Preferred insulin, which includes commercially available insulin preparations including insulin analog preparations available in either vial or cartridge;
f. Preferred syringes, which includes insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices and other disposable parts required for insulin injection aids;

g. Preferred prescription oral agents of each class approved by the FDA for treatment of diabetes, and a variety of drugs, when available, within each class; and
h. Preferred glucagon kits.

6. **Flu and Pneumonia Shots**.

7. **Healthy Pregnancy Counseling.** Coverage will include, but not limited to, counseling, screening, and vaccines.

8. **Vaccinations.** Coverage will be provided for routine vaccinations against diseases such as measles, polio, or meningitis, or other diseases specified for vaccination in the federal Affordable Care Act.

9. **Well-Baby and Well-Child Care Visits.** Coverage will be provided for regular well-baby and well-child care visits, as from birth to age 18, unless otherwise stipulated in the federal Affordable Care Act. Benefits will include, but not limited to, the following: (a) a history; (b) physical examination; (c) developmental assessment; (d) anticipatory guidance; (e) laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided in state law; (f) routine immunizations according to the schedule for immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services or as recommended by the American Committee on Immunization Practices.

   Services for Well-Baby and Well-Child Care must be provided by the Primary Care Physician or other Participating Provider supervised by the Primary Care Physician.

"Developmental assessment" and "anticipatory guidance " mean the services described in the Guidelines for Health Supervision II, published by the American Academy of Pediatrics. :

For more detailed information on Preventive Care Services, the Covered Person can obtain the information: (a) from the sources listed below; (b) on Our website; or (c) by contacting Customer Service; refer to page 2 for contact information.

1. Services that have an “A” or “B” rating* in the United States Preventive Services Task Force’s current recommendations;
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention;

3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;
4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to November 2009; and
5. Any other Preventive Health Care Services required by the federal Affordable Care Act.

Prosthetic and Orthotic Devices Benefit

Coverage is provided for prosthetic eyes. Prosthetic eyes are replaceable every 5 years.

Coverage is provided for prosthetic breasts due to reconstructive surgery and prosthetic eyes. Prosthetic breasts are replaceable every 2 years and prosthetic eyes are replaceable every 5 years.

Coverage is provided for prosthetic limbs at a maximum of $5,000. Prosthetic device means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg. It does not include an orthotic device or breast prostheses.

The Covered Person will have access to: (1) Medically Necessary prosthetic clinical care; and (2) prosthetic devices and technology from one or more prosthetic Participating Providers.

Specifically excluded are hearing aids, cochlear implants, and foot orthotics and shoe inserts.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

“Orthotic device" means a rigid or semi-rigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.

“Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg. It does not include an orthotic device.

Reconstructive Surgery Benefit

Coverage will be provided for reconstructive surgery (non-cosmetic surgery) performed on abnormal structures of the body caused by:

1. Congenital defects;
2. Developmental abnormalities;
3. Trauma;
4. Infection;
5. Tumors; or
6. Disease, which restores bodily function.

Also, refer to the Breast Surgery, Reconstruction and Prostheses Benefit.

Rehabilitation/Habilitation Therapy Benefit

Coverage is provided for the treatment of disease, injury, developmental delay or other cause, by physical agents and methods to assist in the rehabilitation/habilitation of normal physical bodily function, that is goal oriented and where the Covered Person has the potential for functional improvement and ability to progress.

Skilled Nursing Facility Benefit

Coverage will be provided in a Skilled Nursing Facility when prescribed by a Participating Provider. Preauthorization is required.

Surgical Benefits

Coverage is provided for Medically Necessary Surgical Procedures when performed in:

1. A Physician's office;
2. A Hospital; or
3. A Freestanding Ambulatory Surgical Facility.

Coverage includes services of an Assistant Surgeon when Medically Necessary. Services of a co-surgeon, when required and in the absence of an Assistant Surgeon, are payable up to the combined total amount eligible per Maximum Allowable Fee for the surgeon and an assistant's fee, divided equally.

The services for an assistant surgeon are allowable up to 20% of Maximum Allowable Fee.

Coverage also includes the services of the following:

1. A Certified Assistant Surgical Nurse; or
2. A Physician's Assistant at Surgery;

in lieu of an Assistant Surgeon are allowable up to 10% of Maximum Allowable Fee.

Second Opinion and Surgical Review

Coverage is provided for a second opinion evaluation for Surgery. Available Medical Records, including x-rays, should be forwarded to the Provider for the second opinion evaluation.

Refer to *Section 9, Limitations and Exclusions*, for benefit limitations and excluded services.

Urgent Care Facility Benefit

Coverage is provided for Medically Necessary Urgent Care facility services when treatment of a medical condition, that if left untreated, may cause unnecessary suffering and prolonged treatment to restore the Covered Person's health.

SECTION 6 – UTILIZATION REVIEW MANAGEMENT PROGRAM

Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed Treatments and elective procedures are Medically Necessary and appropriate.

Prospective Utilization Review requires the Covered Person to obtain Preauthorization for certain prescribed Treatments and elective procedures before the Treatments and procedures are rendered. If Preauthorization is not obtained, there is a 50% reduction in payment to the Network Provider. The Covered Person must contact the Utilization Review Management Program Manager to obtain the Prior Approvals. The Utilization Review Management Program Manager is shown on page 2, *Important Information Regarding Your Group Policy*.

How To Use The Utilization Review Program

To use the Utilization Review Management Program, the Covered Person need only to call its toll-free telephone number listed on page 2, *Important Information*. The Covered Person may have his or her representative place the call. A representative may be the Physician, the Covered Facility, or his or her authorized representative (e.g., family member). The Utilization Review Management

Program Manager will give the individual who calls a reference number to verify that the call has been received and a file started.

The individual who calls the Utilization Review Management Program Manager will need to provide the following information:

- The name and Member ID number of the Covered Person for whom Treatment has been prescribed and requires Prior Approval (Preauthorization);
- The Covered Employee's name and this Group Policy's Group Policy Number which is shown in the Schedule of Benefits;
- The name and telephone number of the attending Physician;
- The name of the Covered Facility where the Covered Person will be admitted, if applicable;
- The proposed date of admission, if applicable; and
- The proposed Treatment.

PLEASE NOTE: Authorization by the Utilization Review Management Program Manager does not verify a Covered Person's eligibility for coverage under this Group Policy, nor is it a guarantee that benefits will be paid for a proposed Treatment. Benefit payment will be made for a Covered Person only in accordance with all the terms and conditions of this Group Policy.

Utilization Review Management does not include:

1. Routine claim administration; or
2. Determination that does not include determinations of Medical Necessity or appropriateness.

Medical Treatments Requiring Preauthorization

Preauthorization must be obtained for:

1. Benefits that specify that Preauthorization is required; and
2. Procedures listed in the Preauthorization Medical Treatments List.

Statement of Preauthorization

When We require Preauthorization for coverage under this Group Policy, We will provide the Covered Person with a statement of preauthorization if:

1. The applicable CPT codes have been submitted to Us to determine whether a particular procedure is covered under the terms of this Group Policy;
2. The Covered Person has met the requirements for Preauthorization of the procedure or encounter; and
3. The Covered Person requests a statement of Preauthorization.

The statement of preauthorization may be sent: (1) by mail; or (2) electronically.

The statement of preauthorization will include a statement that the Preauthorization is:

1. Not a guarantee of payment by Us; and
2. Subject to the conditions, exclusions, limitations, and provisions of this Group Policy.

Preauthorization Medical Treatment

The following medical Treatments require Preauthorization:

- Brachytherapy

- Capsule endoscopy
- Cardiac nuclear medicine scans
- Chiropractic services (after initial consultation)
- Cochlear implants
- Cognitive function testing, psychological testing, and behavioral assessment
- Computed Tomography Angiograms (CTA) and Magnetic Resonance
- Angiograms (MRA)
- Durable medical equipment (DME), including prosthetics, orthotics and corrective appliances which cost more than $500
- Eyeglasses and contact lenses (after cataract surgery, or for other covered conditions as provided in this Group Policy)
  Health education services
  Foot care, if done by podiatrist
- Home health care
- Home infusion services
- Hospice services (inpatient and outpatient)
- Hyperbaric oxygen therapy services
- Implantable medications and devices
- Inpatient rehabilitation admissions
- Intraoperative electrophysiological monitoring
- Joint Replacements
- Magnetoencephalography (MEG)
- Medical coverage of dental services
- Mental health/substance abuse services - Contact MHNet at 1-800-701-8663
- Neuropsychological testing
- Occupational therapy, including evaluation
- Orthotics, prosthetics and corrective appliances
- Outpatient facility or office surgeries and procedures
  A. Abortion
  B. Arthrodesis
  C. Breast surgery
  D. Cardiac Septum defects
  E. Cardiac Septum defect closure
  F. Circumcision (non-newborn)
  G. Gastric restrictive procedures
  H. Grafts
  I. Jaw surgeries, including TMJ
  J. Oculoplastic procedures
  K. Ophthalmological surgery
  L. Oral Surgery
  M. Salivary gland procedures
  N. Spinal surgeries
  O. Sympathectomy
  P. Umbilical hernia repair (members less than one year old)
  Q. Uvulopalatopharyngoplasty
  R. Vein surgery
- Pain management services
- Physical therapy, including evaluation
- Plastic surgery and related procedures (cosmetic procedures, acne surgery, and similar)
- Proton beam therapy
- Positron-emission tomography (PET) scans
- Skilled nursing facility admissions
- Sleep studies
- Speech therapy, including evaluation
- Telemedicine services

- Three-dimension imaging
- Transplants, including initial evaluation and donor testing
- Transportation (non-urgent)

Utilization Review Process

When the Utilization Review Management Program Manager conducts Utilization Reviews, the Utilization Review will include the following the provisions.

Utilization Review for Mental Health Treatment

When Utilization Review is conducted for outpatient mental health Treatment, the Utilization Review Management Program Manager will only request information that is relevant to the payment of the claim.

When a Utilization Review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or
2. Current and diagnosis of a mental disorder;

the identity of that individual will be concealed from anyone having access to that information in order that the patient or client may remain anonymous.

Request for Information

The Utilization Review Management Program Manager may request only information that is relevant to the payment of a claim for Utilization Review of outpatient mental health treatment.

Disclosure of Personal Information

When a Utilization Review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or
2. Current and past diagnosis of a mental disorder;

the Utilization Review Management Program Manager will conceal the identity of that individual from anyone having access to that information in order that the patient or client may remain anonymous.

Determinations Made on Appeal or Reconsideration

An Utilization Review determination that is:

1. Made on appeal or reconsideration; and
2. Adverse to a patient or to an affected health care provider;

may not be made on a question relating to the necessity or appropriateness of a health care Treatment without prior written findings, evaluation, and concurrence in the Adverse Determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence will be provided to the patient upon his or her written request to the Utilization Review Organization within 30 days of determination.

A determination made on appeal or reconsideration that health care Treatment rendered or to be

rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the patient's attending health care provider concerning the necessity or appropriateness of the health care Treatment.

Also, refer to the Grievance Procedure provision, in Section 10, regarding appeals for adverse determinations.

SECTION 7 – COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

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

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined in Rule 590-126 , school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. The order of benefit determination rules determine whether This plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

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

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

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

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

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

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

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

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

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

- The Plan of the parent whose birthday falls earlier in the policy year is the Primary Plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

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

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage

of the dependent child, the provisions of (a) above shall determine the order of benefits; or

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

- The **Plan** covering the **Custodial parent**;
- The **Plan** covering the spouse of the **Custodial parent**;
- The **Plan** covering the **non-custodial parent**; and then
- The **Plan** covering the spouse of the **non-custodial parent**.

(3) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(4) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary Plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary Plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits

(5) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary Plan** and the COBRA or state or other federal continuation coverage is the **Secondary Plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(6) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, Group Policyowner, subscriber or retiree longer is the **Primary Plan** and the **Plan** that covered the person the shorter period of time is the **Secondary Plan** .

(7) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary Plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary Plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary Plan**. The **Secondary Plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary Plan**, the total benefits paid or provided by all **Plans** for the claim

do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary Plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. Our Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. Our Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Our Claims Administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION 8 – LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS AND LIMITATIONS

All Covered Benefits provided under this Group Policy are subject to the following exclusions and limitations in this Section and as provided in *Section 6, Covered Benefits*. Additionally, specific exclusions and limitations for certain Covered Benefits are provided in this Section 9, as referenced in *Section 6, Covered Benefits*.

No benefits will be paid under this Group Policy for the following:

1. Services compensable under Worker's Compensation or Employer's Liability Laws.
2. Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the Covered Individual is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
3. Services, supplies and devices relating to the treatments or related procedures for: (a) acupuncture; or (b) acupressure.
4. Bariatric Surgery, including complications.
5. Biofeedback or Neurofeedback.

6. Cosmetic Surgery, including complications of cosmetic surgery. However, this exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.
7. Dry needling procedures.
8. Temporomandibular Joint Dysfunction (TMJ).
9. Dental anesthesia.
10. Routine eye exams, eyeglass lenses, and frames for adults.
11. General anesthesia administered in a Physician's office.
12. Any services, supplies, drugs and devices which are: (a) an investigational/Experimental Service or Clinical Trial, unless conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition; (b) not accepted medical practice; and (c) not a Covered Medical Expense. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted-medical practices.
13. Long-term care services, or Custodial Care.
14. Charges for services needed as a result of illegal activities, including participation in a felony, riots, or insurrection when You are a voluntary participant.
15. Infertility treatment.
16. Charges for services needed as a result of a vehicular accident, whether on or off road, when operating the motor vehicle while illegally impaired.
17. Routine, preventive or restorative dental services for adults.
18. Neutron beam.
19. 19.Refractive eye surgery, including radial keratotomy, LASIK or other corrective vision procedures.
20. Non-urgent or non-emergency care when traveling outside of Utah.
21. Gender reassignment treatment or surgery.
22. Hearing aids.
23. Gene Therapy.
24. Routine foot care.
25. Reversal of sterilization.
26. Residential treatment programs, including wilderness.
27. Sleep Apnea diagnosis or treatment.
28. Weight loss programs.
29. Immunizations required for travel or military service.
30. Immunizations for anthrax, tuberculosis, cholera, typhoid or yellow fever.
31. Methadone Therapy.
32. Prolotherapy, Radiofrequency ablation of dorsal root ganglion and IV pamidronate therapy for the treatment of reflex sympathetic dystrophy.
33. Pervasive Developmental Disorder.
34. Sexual dysfunction, except when caused by surgical or medical treatments.
35. Balloon sinuplasty,
36. Lovaas therapy.
37. Intimal media thickness testing.
38. Magnetic Source Imaging.
39. Mole mapping.
40. Whole body scanning.
41. Skin tag removal.
42. Treatment for hyperhidrosis or sialorhea.

43. Services for crossmatching and/or harvesting organs when the recipient in not a Covered Person.
44. Routine follow-up care provided in an emergency room.
45. Holistic or homeopathic treatments.
46. Services provided by a member of the patient's immediate family or household, or charges for which the patient is not responsible.
47. New procedures, services, supplies, and medications until they are reviewed for safety, efficacy and cost effectiveness and approved by Us.
48. Experimental or investigational treatment, procedures, tests, equipment, or facilities, or any health care service which is still undergoing evaluation and review.
49. Sensitivity training, anger management, or other personality or conduct disorder therapy or treatments.
50. Milieu therapy.
51. Educational, training, work or court ordered mental health treatments or courses.
52. Electrosleep or electronarcosis therapy.
53. Neuropsychological Testing and Treatment for autism, chronic fatigue, attention deficit, hyperactivity, learning disability, Tourette's, or mental retardation reasons that are not considered diagnostic or medical management in nature.
54. Biofeedback therapy for mental health services.
55. Psychosexual disorders including gender identity, psychosexual dysfunctions or transexualism.
56. Chronic organic brain syndrome.
57. Difficult life circumstances not part of treatment for a recognized mental illness.
58. Family, marriage or relationship counseling.
59. The following Medical Equipment and Services and Supplies:

a. Orthopedic and corrective shoes, arch supports, orthotic shoe inserts or heel pads or cups.
b. Training for use of durable medical equipment.
c. Medically inappropriate durable medical equipment.
d. TENS unit.
e. Neuromuscular stimulators.
f. H-wave electronic device.
g. Sympathetic Therapy Stimulator (STS).
h. Machine purchase or rental for the treatment of sleep disorders.
i. Corsets, trusses, support hose or elastic stockings.
j. Lumbosacral supports.
k. Anodyne infrared device.
l. Automated home blood pressure monitoring equipment.
m. Freestanding/home cervical traction.
n. Home anticoagulation or hemoglobin A1C testing.
o. Pediatric or infant scales.
p. Pressure Specified Sensory Device for neuropathy testing.
q. Routine service and cleaning of durable medical equipment.

SPECIFIC LIMITATIONS AND EXCLUSIONS FOR CERTAIN COVERED BENEFITS

Diagnostic testing, Lab and X-Ray

No benefits will be payable for the following:

1. Routine drug screening.
2. Sublingual or colorimetric allergy testing.
3. Charges in conjunction with weight loss programs regardless of Medical Necessity.
4. Epidemiological and predictive genetic counseling except in conjunction with the Affordable Care Act.
5. Probability and predictive analysis and testing.
6. Unbundling of lab charges or panels.
7. Medical or psychological evaluations or testing for legal purposes such as: (a) paternity suits; (b) custodial rights, etc.; or (c) for insurance or employment examinations.
8. Hair analysis, trace elements, or dental filling toxicity.
9. Assisted reproductive technologies, including but not limited to: (a) invitro fertilization; (b) gamete intra fallopian tube transfer; (c) embryo transfer; (d) zygote intra fallopian transfer;(e) pre-embryo cryopreservation techniques; and/or (f) any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
10. Sleep Studies for sleep disorders.
11. Services in conjunction with diagnosing infertility.
12. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.
13. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease.

Durable Medical Equipment/Supply

Limitations

1. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
2. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty.
3. Artificial eye prosthetic, when made necessary by loss from an injury or illness, must be Preauthorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Preauthorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.
4. Wheelchairs require Preauthorization through Our Utilization Review Management Program and are limited to one power wheelchair in any five-year period.
5. Knee braces are limited to one per knee in a three-year period.

Exclusions

No benefits will be payable for the following:

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following Surgery for corneal transplant.
3. Durable Medical Equipment that is inappropriate for the patient's medical condition.
4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit.
5. Equipment purchased from non-licensed Providers.
6. TENS Unit.
7. Neuromuscular Stimulator.
8. H-wave Electronic Device.
9. Sympathetic Therapy Stimulator (STS).
10. Machine rental or purchase for the treatment of sleep disorders.
11. Support hose for phlebitis or other diagnosis.
12. Any other equipment or supply not authorized by Our Utilization Review Management Program

Home Health Care and Hospice Care Services

Limitations

1. Total Enteral Nutrition (TEN) formula requires Preauthorization and must be obtained through the Participating Pharmacy.
2. Physical and/or occupational therapy performed in the home is subject to any Outpatient benefit limits shown in the Schedule of Benefits.
3. A home visit by a Licensed Clinical Social Worker is payable under the Outpatient Mental Health benefit provided under this Group Policy.
4. Skilled Nursing visits are subject to any limitations provided under this Group Policy for Skilled Nursing visits.
5. Home Health Care Services and Hospice Care services are subject the Exclusions and Limitations provided under this Group Policy.
6. Hospice Services will be limited to six months per three years.
7. Home Health Care Services will be limited to thirty visits per year.

Exclusions

No benefits will be payable for the following:

1. Nursing or aide services which are requested by or for the convenience of the Covered Person or his or her family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Participating Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to the Participating Provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral Nutrition, unless obtained through the Prescription Drug Benefit

Medical Visits

Limitations

1. The following therapy services visits will be payable up to the visit limit, if any, for such therapies as provided in this Group Policy and shown on the Schedule of Benefits : (a) physical therapy; and (c) Outpatient occupational therapy for fine motor function. Such therapy visits must be Medically Necessary.
2. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis when billed by Participating Providers of the same specialty for any one Covered Person is allowable. Same-day visits by a multi-disciplinary team are eligible with applicable Coinsurance(s) per Participating Provider.
3. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses.
4. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on-call" or shift work requirements.
5. Cardiac Rehabilitation, Phase 2, following are payable up to 5 visits combined per Policy year: (a) heart attack; (b) cardiac Surgery; (c) severe angina (chest pain); and (d) Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery.

Mental Health Benefit – Mental Illness and Substance Abuse

Limitations

1. Benefits for group family counseling will be payable under this Mental Health Benefit for the Covered Person who is the primary patient. Benefits will not be considered separate for each individual family member.
2. When an Inpatient stay spans an old and new Policy year, Hospital benefits will be based on the prior (old) Policy year Group Policy provisions. Actual number of days used, however, will apply to specific Policy years.
3. Inpatient Participating Provider visits are payable only in conjunction with authorized Inpatient days, and will apply to benefits in effect during the Policy year on the actual date of service billed.
4. Outpatient visits are limited to the Maximum Number of Outpatient Visits per Policy year shown in the Schedule of Benefits.

Exclusions

No benefits will be payable for the following:

1. Inpatient treatment for Mental Health without Preauthorization.
2. All of the following are not covered under this Group Policy: (a) Milieu therapy; (b) marriage counseling; (c) encounter groups; (d) hypnosis; (e) biofeedback; (f) parental counseling; (g) stress management or relaxation therapy; (h) conduct disorders; (i) oppositional disorders; (j) learning disabilities; and (k) situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.
5. Inpatient treatment for: (a) behavior modification; (b) enuresis; or (c) encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or recreational therapy.
8. Hospital leave of absence charges
9. Sodium amobarbital interviews.
10. Residential treatment programs.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating Physician.

Inpatient and Outpatient Hospital, Covered Facilities, and Emergency Room Services

Exclusions

1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: (a) guest trays; (b) cots; (c) telephone calls; (d) shampoo; (e) toothbrush; or (f) other personal items.
4. Occupational therapy for: (a) activities of daily living; (b) academic learning; (c) vocational or life skills; and (d) developmental delay.
5. Care, confinement or services in: (a) a nursing home; (b) rest home or a transitional living facility; (c) community reintegration program; (d) vocational rehabilitation; (e) services to re-train self-care; or (f) activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is a Covered Person, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications.

12. Additional fees charged because a robotic surgical system was used during surgery.
13. Mastectomy for gynecomastia.
14. Breast reduction.
15. Tests and treatment for infertility.
16. Blepharoplasty (or other eyelid Surgery).
17. All facility claims related to a Hospital stay when the Covered Person is discharged against medical advice.
18. Sclerotherapy of varicose veins.
19. Microphlebectomy (stab phlebectomy).
20. Inpatient or outpatient dental hospitalization
21. Charges for ambulance services, Physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable Group Policy provisions and any specified Coinsurances.
22. Newborn nursery room charges are separate from the mother's claim, and the child must be enrolled in accordance with the Eligibility requirements to be eligible.
23. When an Inpatient Hospital Stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, We may require the patient to be transferred to such unit or facility.

Prescription Drugs

Exclusions

1. Nonlegend drugs other than insulin.
2. Anabolic Steroids.
3. Fluoride supplements, unless otherwise noted on the formulary.
4. Over-the-counter drugs that do not require a prescription, unless otherwise noted on the formulary.
5. Any drug used for the purpose of weight loss.
6. Prescription Drugs for cosmetic purposes, including the Treatment of alopecia (hair loss), e.g., Minoxidil, Rogaine.
7. Prescription Drugs used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered if Medically Necessary and the Covered Person receives Preauthorization.
8. Therapeutic devices or appliances, including needles, syringes, support garments, and other nonmedicinal substances, regardless of intended use, unless otherwise specified as a covered benefit under this provision.
9. Diabetic infusion sets, which include a cassette, needle and tubing, and one insulin-pump during the warranty period. Diabetic-infusion sets and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
10. Drugs or items labeled "Caution – limited by federal law to investigational use, or experimental drugs even though the Covered Person is charge for the item.
11. Immunization agents, biological sera, blood, or blood plasma.
12. Prescription Drugs which are to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medications in these situations is part of the facility's charge.
13. Any Prescription Drug refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
14. Replacement prescription Drugs or Prescription Drugs due to loss, theft or spoilage.

Surgical Services

Limitations

1. Multiple Surgical Procedures during the same operative session are allowable at 100% of Maximum Allowable Fee for the primary procedure and 50% of Maximum Allowable Fee for all additional eligible procedures. Incidental procedures are excluded.
2. Surgical benefits are payable based on surgical Package Fees to include the Surgery and post-operative care per CPT guidelines and RBRVS guidelines.
3. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Pre-authorization through Medical Case Management.
4. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when a the Covered Person is edentulous (absence of all teeth) and the general health of the Covered Person is at risk because of malnutrition or possible bone fracture. If the Covered Person elects a more elaborate or precision procedure, We may allow payment for the standard Calcitite placement towards the cost and the Covered Person will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible. Preauthorization is required; refer to Section 6, *Utilization Review Management Program*.

Exclusions

No benefits will be payable for the following:

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, Bariatric, stomach stapling, gastric balloons, etc., including any present or future Complications.
4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
    a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes; and
    b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years.
6. Assisted reproductive technologies: (a) invitro fertilization; (b) gamete intra fallopian tube transfer; (c) embryo transfer;(d) zygote intra fallopian transfer; (e) pre-embryo cryopreservation techniques; and/or (f) any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
7. Surgical treatment for correction of refractive errors.
8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Covered Person or when the transplant for the Covered Person is not eligible.
9. Reversal of sterilization.
10. Gender reassignment Surgery.
11. Rhytidectomy.
12. Surgery that is dental in origin, including: (a) care and treatment of the teeth, gums, or alveolar process; (b) extraction of teeth; (c) dental implants and crowns or pontics over implants; (d) re-implantation or splinting; (e) endodontia; (f) periodontia; (f) orthodontia, and (g) anesthesia or supplies used in such care.
13. Complications as a result of non-covered or ineligible Surgery.
14. Injection of collagen, except as approved for urological procedures.
15. Lipectomy, abdominoplasty, panniculectomy.
16. Repair of diastasis recti.
17. Sperm banking system, storage, treatment, or other such services.

18. Non-FDA Approved or Experimental or Investigational procedures, drugs and Devices.
19. Hair transplants or other treatment for hair loss or restoration.
20. Chemical peels.
21. Treatment for spider or reticular veins.
22. Liposuction.
23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.
26. Any Surgery solely for snoring.
27. Otoplasty.
28. Abortions, except as in accordance with Utah State Law.
29. Surgical treatment for sexual dysfunction.
30. Subtalar implants.
31. Additional fees charged because a robotic surgical system was used during surgery.
32. Mastectomy for gynecomastia.
33. All treatment of infertility.
34. Breast Reduction.
35. Blepharoplasty (or other eyelid Surgery).
36. Circumcision for adults
37. Infertility surgery.
38. Sclerotherapy of varicose veins.
39. Microphlebectomy (stab phlebectomy).
40. TMJ/TMD/Myofacial Pain.

SECTION 9 – CLAIM PROVISIONS

No claims are required to be submitted when services are provided by the Covered Person's Primary Care Provider or other Participating Provider in the Network.

HOW TO FILE A CLAIM

When a Covered Person receives services from a Non-Participating Provider due to Emergency Care Services, he or she should file a claim with Us only if the Non-Participating Provider does not file a claim for the Covered Person.

Notice of Claim

Written notice of claim must be given to Us within 30 days of the date of loss. Written notice of claim given by or on behalf of the Covered Person to Us with information sufficient to identify such Covered Person will be considered notice to Us. Failure to give notice within the 30 days will not invalidate any claim if it is shown that it was not reasonably possible to give written notice of claim within that time and that written notice of claim was furnished as soon as reasonably possible.

Proof of Loss

Written proof of loss must be given to Our Claims Administrator, the address is shown on page 2, of this Group Policy within 90 days from the date of loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time Payment of Claims

Benefits payable under this Group Policy for any loss for which a claim is submitted will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

We will pay benefits to the Covered Person when Covered Medical Expenses are incurred for Emergency Care Services rendered by a Non-Participating Provider. The Covered Person may assign the claim payment to the Non-Participating provider.

COMPLAINTS AND APPEALS

Complaint Resolution.
If You have a concern or a request for reconsideration regarding an Adverse Benefit Determination, You must follow the Grievances and Appeals internal review process detailed below. Any questions or requests for information that You may have about the Grievances and Appeals internal review process can be mailed to:

Coventry Health Care of Utah of Utah, Grievances and Appeals Department
10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095
Phone: 855-449-2889

Any request for reconsideration of an Adverse Benefit Determination that is based on medical judgment will be reviewed by a committee that includes a Physician. If necessary, the committee will consult a health care professional, or professionals, who have appropriate training and experience in the field of medicine related to the subject of the Adverse Benefit Determination.

You must follow these steps to resolve any complaints or Grievances regarding Your health care Coverage:

Standard Appeals.

You may file a formal written Appeal of an Adverse Benefit Determination with Coventry Health Care of Utah Grievances and Appeals Department. Any individual You designate as an authorized representative, including Your health care Provider, may also write an Appeal on Your behalf. A written Appeal must be filed no later than one-hundred eighty (180) calendar days from the date You received notification of the Adverse Benefit Determination. Coventry Health Care of Utah's review of the Appeal will be based only on the information You provide, such as medical records. The Grievances and Appeals Department will investigate the issue, and submit the Appeal with all relevant information to the appropriate Appeals committee for review and determination. You or Your authorized representative may review the claim file and present information to the committee in writing or by telephone. None of the committee members will have been involved in the initial decision. The Appeals committee will notify You in writing of the decision within the following timeframes:

- Post Service Claims (services have already been obtained) – sixty (60) days from receipt of Your Appeal
- Pre Service Claims (services that have not been obtained) – thirty (30) days from receipt of Your Appeal

If the Appeals committee intends to uphold the initial denial after reviewing the Appeal, Coventry Health Care of Utah will provide You with any new or additional information or rationale considered in the Appeal process. The information will be given to You as soon as possible, to allow You to respond prior to the date the committee's final decision is due. Any additional information You choose to provide in response will be presented to the Appeals committee for a final decision.

Expedited Appeals.

You may request an expedited review of Your Appeal when the above timeframes would result in the following:

a) Seriously jeopardize Your life or health, or Your ability to regain maximum function; or
b) In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Yur Appeal.

Requests for expedited reviews of Appeals can be made either orally or in writing. All necessary information regarding the Appeal will be transmitted between You and Coventry by telephone, facsimile, email, or other available similarly expeditious method. You or Your authorized representative may review the claim file and present information to the Appeals committee in writing or by telephone. You will be notified of the review decision as soon as possible, but not later than seventy-two (72) hours after receipt of the Appeal.

In the event that You are not satisfied with the outcome of the Grievances and Appeals internal review process, You may choose to bring civil action against Coventry Health Care of Utah. If Coventry Health Care of Utah fails to follow the established Appeals procedure, You will be entitled to pursue civil action before completing the Grievances and Appeals internal review process of this Contract.

In addition to Your right to bring a civil action, You may have the right to proceed with an Independent Review.

Voluntary Independent Review.

If You are not satisfied with the outcome of the Grievances and Appeals internal review process of this Contract, You may have the right to have Coventry Health Care of Utah's decision reviewed by health care professionals who have no association with Coventry Health Care of Utah. You have this right only if Coventry Health Care of Utah decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested; or if Coventry Health Care of Utah rescinded Your coverage; or if Coventry Health Care of Utah determined that the service or treatment was Experimental or Investigational. If You choose to request independent review, the independent review decision will be binding and final, except to the extent that other remedies are available under federal or state law.

Except when agreed upon by both parties, or when Coventry Health Care of Utah fail to follow the established Appeals procedure, the internal review process must be exhausted before an Appeal can be submitted for independent review. If the Appeal meets the requirements described below for an Expedited Independent Review, You may choose to request both internal and independent review at the same time. All requests for independent review must be made within one-hundred eighty (180) days from the date You receive notice of the internal Appeals committee determination. Any statute of limitations or other defense based on timeliness will not be counted during the time that an independent review is pending.

You may submit a written request for an independent review to: Utah Insurance Department, Attn: Independent Review, Suite 3110 State Office Building, Salt Lake City, UT 84114-6901. For more information and for an independent review request form, see the Utah Insurance Department's website at www.insurance.utah.gov. You also may contact the insurance department by email at healthappeals.uid@utah.gov, by fax at 801-538-3829, or by telephone at 801-538-3077 or toll free at 1-800-439-3805.

If Your request qualifies for independent review, the Coventry Health Care of Utah decision will be reviewed by an Independent Review Organization (IRO) selected by the Utah Insurance Department (UID). Coventry Health Care of Utah will pay for the costs of the independent review. In order to have the Appeal reviewed by an IRO, You may be required to sign an authorization granting the IRO access to medical records.

Standard Independent Review

If Your Appeal meets the requirements set forth above, You may have the right to have Coventry Health Care of Utah's decision reviewed by health care professionals who have no association with Coventry Health Care of Utah.

A. If Coventry Health Care of Utah's decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the requested health care service or treatment; or if Coventry Health Care of Utah rescinded Your Coverage, the following independent review process applies:

- Upon the UID's receipt of Your request, the UID will send a copy to Coventry Health Care of Utah for an eligibility review.
- Within five (5) working days after Coventry Health Care of Utah receive Your request from the UID, Coventry Health Care of Utah will review Your request for eligibility. Within one (1) working day after Coventry Health Care of Utah complete the review, Coventry Health Care of Utah will notify You and the UID in writing whether Your request is eligible or what additional information is needed. If Coventry Health Care of Utah denies Your eligibility for review, Coventry Health Care of Utah will provide You and the UID the reason(s) for ineligibility in writing. You may appeal that determination to the UID.
- If Your request is eligible for review, the UID will assign an IRO to Your review upon receipt of Coventry Health Care of Utah notice. The UID will also notify You of the assignment in writing.
- Within five (5) working days of the date You receive the UID's notice of assignment to an IRO, You may submit to the IRO in writing any additional information You want the IRO to consider.
- The IRO must provide written notice of its decision to You, to Coventry Health Care of Utah, and to the UID within forty-five (45) calendar days after receipt of an independent review request.

B. If Coventry Health Care of Utah determined that the health product or service You requested was Experimental or Investigational, the following independent review process applies:

- Upon the UID's receipt of Your request, the UID will send a copy to Coventry Health Care of Utah for an eligibility review. Your request to the UID must include certification from Your Physician that: (1) standard health care service or treatment has not been effective in improving Your condition; (2) standard health care service or treatment is not medically appropriate for You; or (3) there is no available standard health care service or treatment covered by Coventry Health Care of Utah that is more beneficial than the recommended or requested health care service or treatment.
- Within five (5) working days after Coventry Health Care of Utah receives Your request from the UID, Coventry Health Care of Utah will review Your request for eligibility. Within one (1) working day after Coventry Health Care of Utah complete the review, Coventry Health Care of Utah will notify You and the UID in writing whether Your request is eligible or what additional information is needed. If Coventry Health Care of Utah deny Your eligibility for review, Coventry Health Care of Utah will provide You and the UID the reason(s) for ineligibility in writing. You may appeal that determination to the UID.

- If Your request is eligible for review, the UID will assign an IRO to Your review upon receipt of Coventry Health Care of Utah notice. The UID will also notify You of the assignment in writing.
- Within five (5) working days of the date You receive the UID's notice of assignment to an IRO, You may submit to the IRO in writing any additional information You want the IRO to consider.
- Within one (1) working day after receiving the request, the IRO will select one or more clinical reviews to conduct the review. The clinical reviews will provide the IRO a written opinion within twenty (20) calendar days after being selected. The IRO will make its decision based upon the opinion(s) of the clinical reviews and must provide written notice of its decision to You, to Coventry Health Care of Utah, and to the UID within twenty (20) calendar days after receipt of the opinion.

Expedited Independent Review.

You may file a written request for an expedited independent review of Your Appeal if:

- the Appeal meets the criteria stated in Section 7.1.2 of this Contract, or
- the Appeal concerns an admission, availability of care, continued stay, or health care service for which You received emergency services, but You have not been discharged from a facility.

You may choose to file both an internal Appeal with Coventry Health Care of Utah and an expedited independent review with the UID at the same time.

The UID will send Your expedited independent review request to Coventry Health Care of Utah. Coventry Health Care of Utah will determine whether Your request is eligible for review. Upon completion of Coventry Health Care of Utah review, Coventry Health Care of Utah will notify You and the UID whether the request is eligible or what additional information is needed. If Coventry Health Care of Utah deny Your eligibility for review, Coventry Health Care of Utah will provide You and the UID the reason(s) for ineligibility in writing. You may appeal that determination to the UID.

If Your request is eligible for review, the UID will assign an IRO to Your review upon receipt of Coventry Health Care of Utah notice. The UID will also notify You of the assignment. The IRO must provide notice of its decision to You, to Coventry Health Care of Utah, and to the UID within seventy-two (72) hours after the date of receipt of the expedited independent review request. Separate time frames may apply when Your Appeal is based on Coventry Health Care of Utah determination that a health product or service is Experimental or Investigational.

Appeals Regarding Loss of Eligibility Due to Non-Payment of Premium
All Appeals regarding loss of eligibility due to non-payment of Premium must be submitted to the Health Insurance Marketplace, not the Health Plan. Pursuant to federal regulation, all such Appeals shall be determined by the Health Insurance Marketplace.

SECTION 10 – GENERAL PROVISIONS

Entire Contract; Changes

This Group Policy including the application, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Group Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed in or attached to this Group Policy. No agent has authority to change this Group Policy or to waive any of its provisions.

Incontestability

After two (2) years from the Policy Effective Date of this Group Policy, no statements, except fraudulent misrepresentations, made by the You in an application for this Group Policy, will be used to void this Group.

Covered Persons

After two (2) years from the Coverage Effective Date of the Covered Person, no statements, except fraudulent misrepresentations, made by a Covered Person in an enrollment application form coverage under this Group Policy, will be used to void his or her coverage under this Group Policy or to deny a claim for loss incurred or disability (as defined in this Group Policy) commencing after the expiration of such two-year period.

Representations

In the absence of fraud, any statement made by You or any Covered Person will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

What Are the Time Limits on Legal Actions?

Legal Actions: No action will be brought to recover on this Group Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Group Policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Improper payments: If We make improper payments to You or a provider, we may recover the correct amount within 24 months of the amount improperly paid for a coordination of benefits error, or within 12 months of the amount improperly paid for any other reason, and We may take action against a provider involved, if necessary.

Can this Group Policy be Assigned?

This Group Policy cannot be assigned.

Conformity with State Statutes

Any provision of this Group Policy which, on its Group Policy Effective Date, is in conflict with the statutes of the state in which the You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

LARGE GROUP COMPREHENSIVE HEALTH CONTRACT

Non-Contributory
Non-Participating – No Dividends