



HSA

**COMPREHENSIVE MAJOR MEDICAL
PREFERRED PROVIDER ORGANIZATION
GROUP BENEFIT CERTIFICATE**

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM A NON-PREFERRED PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 5.0.), ARE PAID AT A RATE LESS THAN LIKE COVERED BENEFITS RECEIVED FROM A PREFERRED PROVIDER. (SEE YOUR SCHEDULE OF BENEFITS)

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM

**USABLE MUTUAL INSURANCE COMPANY
PO BOX 1151, 320 WEST CAPITOL, SUITE 500
LITTLE ROCK, ARKANSAS 72203-1151**

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call USABLE Mutual Insurance Company's toll-free telephone number for information or to make a complaint at

1-800-519-2583

You may also write to USABLE Mutual Insurance Company at:

**USABLE Corporate Center
320 West Capitol, Suite 500
P.O. Box 1151
Little Rock, AR 72201-1151**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de USABLE Mutual Insurance Company's para obtener información o para presentar una queja al

1-800-519-2583

Usted también puede escribir a USABLE Mutual Insurance Company:

**USABLE Corporate Center
320 West Capitol, Suite 500
P.O. Box 1151
Little Rock, AR 72201-1151**

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O

RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA.

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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TABLE OF CONTENTS

SCHEDULE OF BENEFITS	6
1.0 HOW THE COVERAGE UNDER YOUR INSURANCE PLAN WORKS	7
2.0 PRIMARY COVERAGE CRITERIA	9
2.1 Purpose and Effect of Primary Coverage Criteria.....	9
2.2 Elements of the Primary Coverage Criteria.....	9
2.3 Primary Coverage Criteria Definitions.....	10
2.4 Application and Appeal of Primary Coverage Criteria.....	11
3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN	12
3.1 Professional Services.....	13
3.2 Hospital Services.....	13
3.3 Ambulatory Surgery Center.....	14
3.4 Outpatient Diagnostic Services.....	14
3.5 Advanced Diagnostic Imaging Services.....	14
3.6 Maternity.....	15
3.7 Complications of Pregnancy.....	15
3.8 Therapy Services.....	15
3.9 Psychiatric Conditions and Chemical Dependency (Alcohol and Drug Abuse).....	16
3.10 Emergency Care Services.....	17
3.11 Durable Medical Equipment.....	17
3.12 Medical Supplies.....	18
3.14 Diabetes Treatment.....	19
3.15 Ambulance Services.....	19
3.16 Skilled Nursing Facility Services.....	19
3.17 Home Health Services.....	20
3.18 Hospice Care.....	20
3.19 Oral Surgery.....	20
3.20 Dental Care or Orthodontic Services.....	20
3.21 Reconstructive Surgery.....	21
3.22 Medications.....	21
3.23 Organ Transplant Services.....	26
3.24 Preventive Health Services.....	27
3.25 Medical Foods and Low Protein Modified Food Products.....	29
3.26 Amino Acid-Based Elemental Formulas.....	29
3.27 Prenatal Tests and Testing of Newborn Children.....	29
3.28 Complications from Smallpox Vaccine.....	29
3.29 Autism Spectrum Disorder.....	30
3.30 Acquired Brain Injury.....	30
3.31 Temporomandibular Joint Benefits.....	30
3.32 Miscellaneous Health Interventions.....	30
4.0 SPECIFIC PLAN EXCLUSIONS	31
4.1 Health Care Providers.....	31
4.2 Health Interventions.....	32
4.3 Miscellaneous Fees and Services.....	40
5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES	42

5.1	Network Procedures	42
5.2.	Covered Person’s Financial Obligations for Allowable Charges under the Plan	45
5.3	Other Plans and Benefit Programs.....	46
6.0	ELIGIBILITY STANDARDS	49
6.1	Eligibility for Coverage.....	49
6.2	Effective Date of Coverage.....	50
6.3	Termination of Coverage.....	52
6.4	Continuation Privileges	54
7.0	CLAIM PROCESSING AND APPEALS	56
7.1	Claim Processing.....	56
7.2	Complaints.....	62
7.3	Claim Appeals to the Plan (Internal Review).....	62
7.4	Independent Medical Review of Claims (External Review).....	64
7.5	Authorized Representative.....	66
8.0	OTHER PROVISIONS	67
8.1	Payment of Benefits.....	67
8.2	Right of Rescission.....	67
8.3	Claim Recoveries.....	67
8.4	Amendment.....	68
9.0	GLOSSARY OF TERMS.....	68
10.0	YOUR RIGHTS UNDER ERISA	79

ATTACH SCHEDULE OF BENEFITS

1.0 HOW THE COVERAGE UNDER YOUR INSURANCE PLAN WORKS

- 1.1 Your employer has established and maintains an employee health benefit plan (“Plan”) for employees and their eligible dependents. The Employer administers that Plan and actively promotes the Plan to its employees. The Employer and you, through your premium contributions, have purchased a Plan of insurance benefits provided by the Group Policy and Benefit Certificate issued by USAble Mutual Insurance Company that provides a range of coverage for medical services you may need. This is a very valuable benefit for you, but you should understand clearly that your Plan does NOT cover all medical services, drugs, supplies, tests or equipment (“health interventions” or “interventions”). A Plan covering all health interventions would be prohibitively expensive. For that reason, we have offered and you have purchased a more limited Plan. This document is your guide to what you have and have not purchased; in other words, what is and is not eligible for benefits under your Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical services to be sure you understand what is covered and the limitations on your coverage.**
- 1.2 The philosophy and purpose behind your Plan is that we want you to have coverage for the vast majority of medical needs or emergencies you may face, including most hospital and physician services, prescription drugs, supplies and equipment. However, in order to keep costs of your Plan within reasonable limits, we have deliberately excluded coverage of a number of specific health interventions, we have placed coverage limits on some other interventions, and we have established an overall standard we call the “Primary Coverage Criteria” that each and every claim for benefits must meet in order to be covered under your Plan.
- 1.3 Here is an important thing for you to clearly understand. For any health intervention, there are six general coverage criteria that must be met in order for that intervention to qualify for coverage under your Plan.
1. The Primary Coverage Criteria must be met.
 2. The health intervention must conform to specific limitations stated in your Plan.
 3. The health intervention must not be specifically excluded under the terms of your Plan.
 4. At the time of the intervention, you must meet the Plan’s eligibility standards.
 5. You must comply with the Plan’s Provider network and cost sharing arrangements; and
 6. You must follow the Plan’s procedures for filing claims.
- The following discussion will give you a brief description of each of these qualifications.
- 1.4 **The Primary Coverage Criteria.** The Primary Coverage Criteria apply to ALL benefits you may claim under your Plan. It does not matter what types of health intervention may be involved or when or where you obtain the intervention. The Primary Coverage Criteria are designed to allow Plan benefits for only those health interventions that are proven as safe and effective treatment. The Primary Coverage Criteria also provide benefits only for the less invasive or less risky intervention when such intervention would safely and effectively treat the medical condition; or they provide benefits for treatment in an outpatient, doctor’s office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Examples of the types of health interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of a hospitalization for a minor cold or some other condition that could be treated outside the hospital, or the cost of some investigational drug or treatment such as herbal therapy or some forms of high dose Chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition. Finally, the Primary Coverage Criteria require that if there are two or more effective alternative health interventions, the Plan should limit its payment to the Allowable Charge for the most cost effective intervention. The specific coverage standards that must be met under the Primary Coverage Criteria are outlined in detail in Section 2.0 of this document.
- 1.5 **Specific Limitations in Your Plan.** Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an intervention is really needed, we include coverage for such Health Interventions but place limits on the extent of coverage by limiting the number of Provider visits or treatments, or treatment received during a calendar year or other specified time period. Examples of such limitations include a limit on the number of covered visits for home health services, physical, occupational and speech therapy. Other types of limitations include requirements that an intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written treatment plan or other documentation. Common benefits and limitations are outlined in detail in Section 3.0 of this document. You will note that this document refers

to Coverage Policies we have developed that may address limitations of coverage for a particular service, treatment or drug. You may request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.USABLEMUTUAL.COM.

- 1.6 **Specific Exclusions in Your Plan.** There are many possible reasons why we have selected a particular condition, health care Provider, health intervention, or service to be excluded from your Plan. Some exclusions are based on the availability of other coverage or financing for certain types of injuries. For example, injuries you receive on the job are generally covered by workers' compensation. Other exclusions are based on the need to try to keep your coverage affordable, covering basic health care service needs, but not covering every possible desired intervention. The exclusion for Cosmetic Services is an example of this type of exclusion. The plan excludes coverage of some health care Providers because we believe the Provider is not qualified or because the Provider lacks experience. For example the plan does not cover services rendered by unlicensed Providers or by Hospital residents, interns, students or fellows. Other exclusions are based on our judgment that the need for such health intervention is questionable in many cases, or that the services are of unknown or unproven beneficial effect. Examples of these types of exclusions include biofeedback and cranial electrotherapy stimulation devices, as well as some forms of high dose Chemotherapy and bone marrow transplantation. **Before you undergo treatment or tests, you should review the specific exclusions listed in Section 4.0 of this document. If you have any question about whether a specific exclusion applies, discuss it with your doctor(s). Call our Customer Service representatives if you need assistance.** You may also request a copy of our Coverage Policy with respect to a particular service, treatment or drug by contacting Customer Service at 1-800-519-2583 or, if you have Internet access, you may access our web site at WWW.USABLEMUTUAL.COM

1.7 **Provider Network and Cost Sharing Procedures.**

Your plan does not provide coverage for a health intervention unless it is provided by a Health Care Provider or a Physician as defined in this Plan. See Subsections 9.44 and 9.79.

Your plan does not provide coverage for one hundred percent of the costs associated with covered health interventions. You are expected to pay an initial amount of covered Allowable Charges you incur each calendar year. This amount is called a "Deductible." After you have paid the Deductible, you will pay a percentage of Allowable Charges called "Coinsurance;" Once your covered Allowable Charges reach a specified amount, called "Calendar Year Coinsurance Maximum," the Company will pay one hundred percent of covered Allowable Charges you incur until the end of the calendar year. Provider networks are designed to try to hold down the costs of your Plan through discounted medical fees that the Company has negotiated with these Providers. Your Plan includes incentives in the form of lower Deductible, lower Coinsurance and a lower Calendar Year Coinsurance Maximum to encourage you to consult and seek treatment from physicians, hospitals and other health care Providers who participate in our Provider network, called "Preferred Providers." A full explanation of the Deductible, Coinsurance and Calendar Year Coinsurance Maximum applicable to your Plan are set out in Section 5.0 and the Schedule of Benefits.

You and your physician are always free to make any decision you believe is best for you concerning whether to receive any particular service or treatment, or whether to see any practitioner or Provider (in or out of the network). However, if you go "out-of-network" for services or treatment, your coverage will be reduced or limited to the out-of-network rate. There are exceptions to the network procedures; for example Emergency Care or if, prior to your effective date of coverage, you were engaged with a Non-Preferred Provider for a scheduled procedure and you receive Preauthorization from the Company to continue at the Preferred Provider benefit level for the scheduled procedure. Unless one of these exceptions apply, if you want to receive the full benefit of your Plan, you should check in advance to see if the Provider is a Preferred Provider. Preferred Providers are identified in our published Provider directory, or you may call Customer Service to ask about a specific Provider, or visit our web site at WWW.USABLEMUTUAL.COM.

- 1.8 **Eligibility Standards.** You must be eligible for benefits under your Plan at the time you receive a health intervention. Eligibility standards are set forth in Section 6.0 of this document. Since your coverage is through a group policy, this means you must be an eligible member of the Group, either as an Employee or an eligible Dependent of an Employee. In order to be an eligible member of the Group, you must meet the Group eligibility standards, which often include limited enrollment periods or Waiting Periods before your Group coverage takes effect. In all cases, in order to be considered "eligible" for

coverage, your Plan must be valid and in force at the time the services or treatment are provided. All premiums must be timely paid. It is important to understand the provisions of Section 6.0 that outline the circumstances under which your coverage may terminate under the Plan. This section also describes the special situations provided by state and federal law that allow continued coverage under the Plan for a limited time after you are no longer an Employee or Dependent. This section also describes the circumstances under which you may convert your coverage to an individual policy.

- 1.9 **Claim Filing Procedures.** Your Plan provides procedures that you, your Provider or your Authorized Representative must follow in filing claims with the Company. Your failure to follow these procedures could result in significant delays in the processing of your claim, as well as potential denial of benefits. These procedures are set out in Section 7.0. In addition, Section 7.0 explains how you can appeal a benefit determination in the event you believe that such benefit determination does not comply with the terms of the Plan.
- 1.10 **Plan Administration.** Certain important matters, not otherwise described in this Benefit Certificate, are set out in Section 8.0. Section 9.0 is a glossary of defined terms used in the Benefit Certificate. Finally, Section 10.0 provides information the Plan is required to provide in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

2.0 PRIMARY COVERAGE CRITERIA

- 2.1 **Purpose and Effect of Primary Coverage Criteria.** The Primary Coverage Criteria are set out in this Section 2.0 of this document. The Primary Coverage Criteria are designed to allow Plan benefits for only those Interventions that are proven as safe and effective treatment. Another goal of the Primary Coverage Criteria is to provide benefits only for the less invasive or least risky Intervention when such Intervention would safely and effectively treat the medical condition, or to provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Finally, if there is more than one effective health Intervention available, the Primary Coverage Criteria allow the Plan to limit its payment to the Allowable Charge for the most cost-effective Intervention. Regardless of anything else in this Plan, and regardless of any other communications or materials you may receive in connection with your Plan, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs UNLESS the Primary Coverage Criteria set forth in this Section are met. At the same time, bear in mind that just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under your Plan. For example, a health Intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a non-covered treatment excluded by the Plan. (See Subsection 4.2) As explained in the preceding Section 1.0, the Primary Coverage Criteria represent one category of six general coverage criteria that must be met for coverage in all cases. The Primary Coverage Criteria are as follows:
- 2.2 **Elements of the Primary Coverage Criteria.**

In order to be covered, medical services, drugs, treatments, procedures, tests, equipment or supplies ("Interventions") must be recommended by your treating physician and meet all of the following requirements:

1. The Intervention must be an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, palliate, or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A "medical condition" means a disease, illness, injury, pregnancy or a biological or psychological condition.
2. The Intervention must be proven to be effective (as defined in Subsections 2.3.1.a. or 2.3.1.b, below) in preventing, treating, diagnosing, detecting, or palliating a medical condition.
3. The Intervention must be the most appropriate supply or level of service, considering potential benefits and harm to the patient. The following three examples illustrate application of this standard (but are not intended to limit the scope of the standard): (i) An Intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to more invasive procedures or greater risks when less invasive procedures or less risky Interventions would be safe and effective to diagnose, detect, treat or palliate a medical condition. (ii) An Intervention is not appropriate, under the Primary Coverage Criteria, if it involves hospitalization or other intensive treatment settings when the Intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the

home. And (iii) Maintenance Therapy is another example of this standard because under the Primary Coverage Criteria, chiropractor services or other physical therapy, speech or occupational therapy, are not considered appropriate for purposes of coverage if the frequency or duration of therapy reaches a point of maintenance where the patient remains at the same functional level and further therapy would not improve functional capacity or ambulation.

4. The Primary Coverage Criteria allows the Plan to limit its coverage to payment of the Allowable Charge for the most cost-effective Intervention.

“Cost-effective” means a health Intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health Intervention. For example, if the benefits and risks to the patient of two alternative Interventions are comparably equal, a health Intervention costing \$1,000 will be more cost effective than a health Intervention costing \$10,000. “Cost-effective” shall not necessarily mean the lowest price.

2.3 **Primary Coverage Criteria Definitions.** The following definitions are used in describing the elements of the Primary Coverage Criteria:

1. **Effective defined**

- a. An existing Intervention (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed “effective” for purposes of the Primary Coverage Criteria if the Intervention is found to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:
 - i. scientific evidence, as defined in Subsection 2.3.2, below (where available); or
 - ii. if scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training and experience in the relevant medical field or subject area; or
 - iii. if scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified in Subsection 2.3.3, below, may be consulted.
 - iv. If neither scientific evidence, expert opinion nor professional standards show that an existing Intervention will achieve its intended purpose to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition, then the Company may find that such existing Intervention is not effective and on that basis fails to meet the Primary Coverage Criteria.
- b. A new Intervention (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed “effective” for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined in Subsection 2.3.2, below) showing that the Intervention will achieve its intended purpose and will prevent, cure, alleviate, or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. Scientific evidence is deemed to exist to show that a new Intervention is **not** effective if the procedure is the subject of an ongoing phase I, II, or III trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new Intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new Intervention shall be deemed “not effective,” and therefore not covered in accordance with the Primary Coverage Criteria, with one exception—if there is a new Intervention for which clinical trials have not been conducted because the disease at issue is rare or new or affects only a remote population, then the Intervention may be deemed “effective” if, but only if, it meets the

definition of “effective” as defined for existing Interventions in Subsection 2.3.1.a, above.

2. **Scientific Evidence defined.** “Scientific Evidence,” for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:
 - a. Results of randomized controlled clinical trials, as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an Intervention on a medical condition. For purposes of this Subsection a., “authoritative medical and scientific literature” shall be such publications as are recognized by the Company, listed in its Coverage Policy or otherwise listed as authoritative medical and scientific literature. You may contact Customer Service at 1-800-519-2583 or access the Company’s web site at WWW.USABLEMUTUAL.COM; or
 - b. Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by the Company. For purposes of this Subsection b. an independent technology or pharmaceutical assessment organization shall be considered “authoritative” if it is recognized as such by the Company, listed in its Coverage Policy or otherwise listed as authoritative. You may contact Customer Service at 1-800-519-2583 or access the Company’s web site at WWW.USABLEMUTUAL.COM.
3. **Professional Standards defined.** “Professional standards,” for purposes of applying the “effectiveness” standard of the Primary Coverage Criteria to an existing Intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by the Company’s Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations. The Company may accept or reject the statements of any professional association or professional accreditation or certification organization as “professional standards” for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as “professional standards” under the Primary Coverage Criteria unless such statements specifically address effectiveness of the Intervention, and conclude with substantial supporting evidence that the Intervention is safe, that its benefits outweigh potential risks to the patient, and that it is more likely than not to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition.

2.4 Application and Appeal of Primary Coverage Criteria.

1. The following rules apply to any application of the Primary Coverage Criteria. The Company shall apply the Primary Coverage Criteria, and interpret any of its terms or phrases, or the manner in which it shall apply to a given Intervention. No Intervention shall be deemed to meet the Primary Coverage Criteria unless the Intervention qualifies under ALL of the following rules:
 - a. **Illegality** - An Intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.
 - b. **FDA Position** - An Intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration (“FDA”), and FDA approval for marketing of the drug or device for a particular medical condition has not been issued prior to your date of service. In addition, an Intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the Intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.
 - c. **Proper License** - An Intervention does not meet the Primary Coverage Criteria if the health care professional or facility administering it does not hold the proper license,

permit, accreditation or other regulatory approval required under applicable laws or regulations in order to administer the Intervention.

- d. Plan Exclusions, Limitations or Eligibility Standards – Even if an Intervention otherwise meets the Primary Coverage Criteria, it is not covered under this Plan if the Intervention is subject to a Plan exclusion or limitation, or if you fail to meet Plan eligibility requirements.
 - e. Position Statements of Professional Organizations - Regardless of whether an Intervention meets some of the other requirements of the Primary Coverage Criteria, the Intervention shall not be covered under the Plan if any national professional association, any accrediting or certification organization, any widely-used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such Intervention or its means or method of administration as “experimental” or “investigational” or as questionable or of unknown benefit. However, an Intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered under the Plan, even if any of the foregoing organizations or groups classify the Intervention as not “experimental” or not “investigational,” or conclude that it is beneficial or no longer subject to question. For purposes of this Subsection e., “national professional association” or “accrediting or certifying organization,” or “national or international workgroup of scientific or medical experts” shall be such organizations or groups recognized by the Company, listed in its Coverage Policy or otherwise listed as authoritative. You may by contact Customer Service at 1-800-519-2583 or access the Company’s web site at WWW.USABLEMUTUAL.COM.
 - f. Coverage Policy – With respect to certain drugs, treatments, services, tests, equipment or supplies, the Company has developed specific Coverage Policies, which have been put into writing, and are published by the Company. You may contact Customer Service at 1-800-519-2583 or access the Company’s web site at WWW.USABLEMUTUAL.COM. If the Company has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.
2. You may appeal a determination by the Company that an Intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator. Use the procedures for appeals outlined in Sections 7.2 and 7.3.
 3. Any appeal available with respect to a Primary Coverage Criteria determination shall be subject to the terms, conditions and definitions set forth in the Primary Coverage Criteria. An appeal shall also be subject to the terms, conditions and definitions set forth elsewhere in this Plan. The Appeals Coordinator or an External Review organization shall render its independent evaluation so as to comply with and achieve the intended purpose of the Primary Coverage Criteria and other provisions of this Plan.

3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments received during a calendar year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network

Provider, refer to Section 5.0, the definition of Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

3.1 **Professional Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following professional services when performed by a Physician. All Covered Services are subject to the applicable Deductible and Coinsurance specified in the Schedule of Benefits. All Covered Services are subject to the applicable Deductible and Coinsurance specified in the Schedule of Benefits.

1. **Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or Accidental Injury when provided in the medical office of a Physician.
2. **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Covered Person is admitted as an inpatient in a Hospital for Covered Services.
3. **Telephone and Other Electronic Consultation.** Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Benefit Certificate,
 - a. Coverage is provided for Telemedicine and Telehealth services performed by a Physician licensed to practice medicine in the state of Texas and operating with his or her own license, at the same rate as if it had been performed in person.
 - b. However, Telemedicine and Telehealth services provided by only synchronous or asynchronous audio interaction or via text-only communication, including, but not limited to, an audio-only telephone consultation, a text-only email or SMS message, or a facsimile transmission, are not covered.
 - c. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers are covered.
4. **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two (2) or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one Physician.
5. **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Company's payment for a covered assistant surgeon shall be limited to one Physician, Advanced Practice Nurse, Physician's Assistant or Surgical First Assistant qualified to act as an assistant for the surgical procedure.
6. **Standby Physicians.** Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk deliveries specified by the Company, and only for such time as such physician is in immediate proximity to the patient.
7. **Abortions.** Abortions are generally not covered, see Subsection 4.2.1. Pregnancy terminations under the direction of a Physician are covered, but only when performed in a Hospital or Outpatient Hospital setting.

3.2 **Hospital Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, including applicable Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following Hospital services. All Hospital services must be performed or prescribed by a Physician and provided by a Hospital.

1. **Inpatient Hospital Services.** This benefit is subject to the following specific limitations:
 - a. Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowable Charge established by the Company.
 - b. Room Allowance: Regardless of whether you are hospitalized in a private or semi-private room, the daily room and board allowance shall not exceed the Allowable Charge for a semi-private room in the admitting Hospital. If you are admitted to a Hospital offering only single occupancy rooms, the daily room and board allowance shall not exceed the Allowable charge for a private room in such Hospital.
 - c. If you have a condition requiring that you be isolated from other patients, the Company will pay for an isolation unit equipped and staffed as such.
 - d. In the event services are rendered for a covered benefit during an inpatient admission

to a Hospital where the admitting diagnosis was for a non-covered benefit, the Company will pay that portion of the Hospital Charge which is attributable to services rendered for the covered benefit.

- e. The services of social workers shall be included in the basic daily room and board allowance.
- f. Hospital admissions to Out-of-Network facilities are subject to Pre-admission Notification. Please call the number listed on the ID Card to notify the Company of the admission.
- g. Services rendered in a Hospital in a country outside of the United States of America shall not be paid except when approved by the Company.
- h. Inpatient care after a mastectomy for a minimum of 48 hours and for a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer unless the Covered Person and his or her attending physician determine a shorter period of inpatient care is appropriate.
- i. Admissions to a Long Term Acute Care Hospital or to a Long Term Acute Care division of a Hospital are subject to Pre-admission Notification. Please call the number listed on the Identification Card to notify the Company of the admission.

2. **Outpatient Hospital Services.** Coverage is provided for services of an Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center.

3. **Hospital Services in Connection with Dental Treatment.** The Company generally does not cover dental services, See Subsection 3.20. However, subject to Preauthorization, coverage is provided for hospital services, including anesthesia services in connection with treatment for a complex dental condition provided to: (i) a Covered Person under seven (7) years of age who is determined by two (2) dentists (in separate practices) to require the dental treatment without delay; (ii) a Covered Person with a diagnosis of serious mental or physical condition; or (iii) a Covered Person, certified by his or her Physician to have a significant behavioral problem. **Please note that if the Company gives Preauthorization for a Health Intervention, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.**

3.3 **Ambulatory Surgery Center.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the same day as such surgical service. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.2.3.

3.4 **Outpatient Diagnostic Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for diagnostic services and materials, including but not limited to, diagnostic imaging (e.g. x-rays, fluoroscopy, ultrasounds, radionuclide studies) electrocardiograms, electroencephalograms and Laboratory tests, as well as an annual low-dose mammography for the presence of occult breast cancer for female Covered Persons who are 35 years of age or older, when performed or prescribed by a Physician and subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

3.5 **Advanced Diagnostic Imaging Services.** Computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRI/MRA"), Nuclear Cardiology and positron emission tomography scans ("PET SCAN") (collectively referred to as "Advanced Diagnostic Imaging") require Preauthorization from the Company. **Please note that if the Company gives Preauthorization for a Health Intervention, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care**

Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.

- 3.6 **Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for maternity care when performed or prescribed by a Physician subject to the Deductible and Coinsurance amounts specified in the Schedule of Benefits.
1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. This includes coverage for inpatient care for a mother and her newborn Child in a health care facility for a minimum of (a) 48 hours following uncomplicated vaginal delivery; and (b) 96 hours following uncomplicated C-section. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.2.98 concerning exclusion of additional routine ultrasounds.
 2. **Midwives.** Services provided by any lay midwife are not covered. See Subsection 4.1.4. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the delivery facility utilized by the certified nurse midwife, in case there is need for assistance during the delivery.
 3. **Genetic Testing.**
 - a. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Covered Person's blood or tissue to determine if the Covered Person has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.
 - b. However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Policy, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Company has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Company will determine which particular genetic tests may be eligible for benefits as an exception to this exclusion. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.
- 3.7 **Complications of Pregnancy.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a Physician subject to the Deductible and Coinsurance amounts specified in the Schedule of Benefits. See Subsection 9.20 for the definition of Complications of Pregnancy.
- 3.8 **Therapy Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits. Physical,

occupational and cardiac therapy, regardless of where the service is performed, is limited to an aggregate maximum of forty-five (45) visits per Covered Person per calendar year.

1. **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including professional services, when performed or prescribed by a Physician and rendered in a Hospital. Inpatient stays for therapy are subject to the Deductible, Coinsurance and benefit maximum specified in the Schedule of Benefits.
2. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. See Subsection 9.76- Outpatient Therapy Visit.
3. **Speech Therapy.** Coverage for speech therapy is limited to a maximum of twenty-five (25) visits per Covered Person per calendar year. However, treatment of speech, language, voice, communication and auditory processing disorder in a group setting is not a covered benefit.
4. **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered. See Subsection 4.2.78.
5. **Cognitive Rehabilitation.** Cognitive Rehabilitation is not covered, except as provided in connection with an Acquired Brain Injury. See Subsections, 3.30, 4.2.18 and 9.17.
6. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.2.80. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.

3.9 **Psychiatric Conditions and Chemical Dependency (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Psychiatric Conditions and Chemical Dependency treatment services when performed or prescribed by a Physician.

1. **Inpatient Psychiatric Conditions.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for inpatient Psychiatric Conditions, (except for Serious Mental Illness) subject to the Deductible and Coinsurance as listed in the Schedule of Benefits.
2. **Psychiatric Day Treatment Facility.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for treatment of Psychiatric Conditions, nervous, mental or emotional disease or disorder in a Psychiatric Day Treatment Facility provided under the direction and continued medical supervision of a Physician. Benefits will be paid on the same basis and to the same extent that applies to Hospital inpatient care and treatment for such diseases or disorders. Each full day of treatment in a Psychiatric Day Treatment Facility is the equivalent of one-half of one day of treatment of Psychiatric Conditions, mental or emotional illness or disorder in a Hospital or inpatient program.
3. **Treatment of Psychiatric Conditions, nervous, mental or emotional disease or disorder in a Residential Treatment Center for Children and Adolescents and in a Crisis Stabilization Unit.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, benefits will be paid on the same basis and to the same extent that applies to Hospital inpatient care and treatment for such diseases or disorders, subject to the following conditions:
 - a. Each two days of treatment in a Residential Treatment Center for Children and Adolescents or in a Crisis Stabilization Unit is the equivalent of one day of treatment of Psychiatric Conditions, mental or emotional illness or disorder in a Hospital or inpatient program; and
 - b. Treatment provided through Crisis Stabilization Units will be reimbursed for facilities licensed or certified by the Texas Department of Mental Health and Mental Retardation.
4. **Outpatient Psychiatric Conditions.** Coverage is provided for outpatient Psychiatric Conditions (except for Serious Mental Illnesses) and substance abuse services. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits. See Subsection 3.9.6 below.

5. **Serious Mental Illnesses.** Unlimited coverage is provided for Serious Mental Illnesses subject to Preauthorization for all outpatient sessions beyond the eighth in a calendar year. Benefits are further subject to the Deductible and Coinsurance as listed in the Schedule of Benefits. See Subsection 3.9.6. below.
 6. **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition. See Subsection 4.2.53.
 7. **Treatment of Chemical Dependency,** of a Covered Person in a Chemical Dependency Treatment Center or other eligible facility, will be paid by the Company on the same basis and to the same extent as for any covered sickness.
 8. **Repetitive Transcranial Magnetic Stimulation Treatment (rTMS).** Coverage is provided for repetitive transcranial magnetic stimulation treatment (rTMS) subject to Preauthorization by the Company. **Please note that if the Company gives Preauthorization for a Health Intervention, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.**
- 3.10 **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Emergency Care. When Emergency Care is needed the Covered Person should seek care at the nearest facility. Emergency Care is subject to the In-Network Deductible and Coinsurance specified in the Schedule of Benefits
1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Emergency Care Deductible and Coinsurance for each visit.
 2. **Transfer to In-Network Hospital.** Continuing or follow-up treatment for Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before you can be safely transferred, without medically harmful or injurious consequences, to an In-Network Hospital. Services are subject to all applicable Deductible and Coinsurance.
 3. **Emergency Hospital Admissions.** You are responsible for notifying the Company of an emergency admission to a Hospital within 24 hours or the next business day.
 4. **Medical Review of Emergency Care.** Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, the Company determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Policy (See Subsection 9.36 - Emergency Care), coverage shall be denied and the emergency room charges will become the Covered Person's liability.
 5. **Allowable Charge.** If you need Emergency Care from an Out-of-Network Provider, the Company will cover you at the highest Allowance or Allowable Charge that federal regulations allow. You will have to pay any charges that exceed the Allowance or Allowable Charge as well as for any Deductibles, Coinsurance and amounts that exceed any benefit maximum.
- 3.11 **Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Durable Medical Equipment (DME) when prescribed by a Physician according to the guidelines specified below. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.
1. Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.
 2. Durable Medical Equipment delivery or set up charges are included in the Allowable Charge for the Durable Medical Equipment.

3. Durable Medical Equipment for which the cost exceeds \$5000 requires Preauthorization from the Company. **Please note that if the Company gives Preauthorization for Durable Medical Equipment, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for any Durable Medical Equipment based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the need for the proposed Durable Medical Equipment or has substantially failed to provide the proposed Durable Medical Equipment. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Durable Medical Equipment may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.**
 4. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowable Charge is based on the cost for basic glasses or contact lenses. You can determine the amount of this Allowable Charge by contacting Customer Service.
 5. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
 6. When it is more cost effective, the Company in its discretion will purchase rather than lease equipment. In making such purchase, the Company may deduct previous rental payments from its purchase Allowance.
 7. Coverage for Medical Supplies used in connection with Durable Medical Equipment is limited to a 90-day supply per purchase.
- 3.12 **Medical Supplies.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Medical Supplies (See Subsection 9.59), other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a Physician.
1. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.
 2. Coverage for Medical Supplies is limited to a 90-day supply per purchase.
 3. Coverage for Medical Supplies used in connection with Durable Medical Equipment, Subsection 3.11 is subject to the Deductible and Coinsurance specified in the Schedule of Benefits. Coinsurance for Medical Supplies used in connection with Durable Medical is not applied to the Calendar Year Coinsurance Maximum.
 4. Expenses for Medical Supplies provided in connection with home infusion therapy are included in the reimbursement for the procedure or service for which the supplies are used.
- 3.13 **Prosthetic and Orthotic Devices and Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for a prosthetic and orthotic devices, including professional services related to their fitting and use, as well as their repair if such device is required for treatment of a condition arising from an illness or Accidental Injury. The Company will provide you the Allowable Charge for a prosthetic or orthotic device. Replacement of a prosthetic or orthotic device is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repair resulting from misuse or abuse of a device are the responsibility of the Covered Person.
- Prosthetic devices to assist hearing or talking devices are not generally covered. See Subsection 4.2.47. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for:
1. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per ear per Covered Person. For Covered Persons 18 years of age or younger, coverage is provided for internal replacement when medically or audiological necessary and for treatment for habilitation and rehabilitation services as necessary for educational gain; and

2. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and
3. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear, subject to Preauthorization. Coverage is further limited to Covered Persons with
 - a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
 - b. chronic external otitis or otitis media;
 - c. tumors of the external canal and/or tympanic cavity; and
 - d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.
4. Prosthetic devices for which the cost exceeds \$20,000 requires Preauthorization from the Company. **Please note that if the Company gives Preauthorization for prosthetic devices, that only means that the Company will not deny or reduce payment to the Health Care Provider for any prosthetic device based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Health Care Provider has materially misrepresented the need for the proposed prosthetic device or has substantially failed to provide the proposed prosthetic device. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The prosthetic device may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.**
5. One hearing aid per ear every three years for Covered Persons 18 years of age or younger. Coverage also includes any treatment related to the hearing aids such as (1) the fitting and dispensing services and the provision so ear molds as necessary to maintain optimal fit, and (2) habilitation and rehabilitation as necessary for educational gain.

3.14 **Diabetes Treatment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, in connection with treatment of diabetes the Company will pay for insulin, diabetes equipment, diabetes supplies (such as hypodermic needles or syringes) and Diabetes Self-Management Training when provided by a Physician or Health Care Provider who is licensed to provide appropriate health care services.

Foot care is generally not covered, see Subsection 4.2.42. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate coverage of foot care is provided when required for prevention of complications associated with diabetes mellitus.

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will cover an eye examination to screen for diabetic retinopathy once per calendar year for Covered Persons who are diagnosed with diabetes.

If provided in Coverage Policy, the Company will pay for Durable Medical Equipment, Medical Supplies and services for the treatment of diabetes. Benefits for Durable Medical Equipment and Medical Supplies provided under this Subsection 3.14 are subject to the Deductible, Coinsurance and benefit limitation set forth in Subsection 3.11 and 3.12. Coinsurance for Medical Supplies used in connection with Durable Medical is not applied to the Calendar Year Coinsurance Maximum.

3.15 **Ambulance Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for ground, water or air Ambulance Services to the nearest hospital in the event Emergency Care is needed. (See Subsection 9.36 Emergency Care.) The coverage for Ambulance Services is subject to the Deductible and Coinsurance specified in the Schedule of Benefits. Payment for ground Ambulance Services may not exceed \$1,000 per trip and for air Ambulance Services may not exceed \$5,000 per trip.

3.16 **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Skilled Nursing Facility services. This benefit is subject to the Deductible and the Coinsurance specified in the Schedule of Benefits. This Skilled Nursing Facility services benefit is subject to the following conditions:

1. The admission must be within seven days of release from an inpatient Hospital stay;
2. A request for Preauthorization must be submitted to the Company prior to admission to the Skilled Nursing Facility. **Please note that Preauthorization does not guarantee payment or**

assure coverage; it means only that the information furnished to us at the time indicates that the Skilled Nursing Facility services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any Skilled Nursing Facility services receiving Preauthorization, must still meet all other coverage terms, conditions, and limitations, and coverage for any Skilled Nursing Facility services receiving Preauthorization may still be limited or denied if, when the claims for the Skilled Nursing Facility services are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.

3. The Skilled Nursing Facility services are of a temporary nature and increase ability to function;
4. Custodial Care is not covered (See Subsections 4.3.7 and 9.28);
5. Coverage is provided for a maximum of 30 days per Covered Person per calendar year.

3.17 **Home Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, including but not limited to the exclusion of Custodial Care (see Subsections 4.3.7 and 9.28), coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. Covered Services must be provided through and billed by a licensed home health agency. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to you by blood or marriage or does not ordinarily reside in your home. Home Health visits are subject to the Deductible and Coinsurance specified in the Schedule of Benefits and are further limited to forty (40) visits per Covered Person per calendar year. (Home infusion services are not covered by this Section 3.17, but are covered under Subsection 3.22.1.d.).

3.18 **Hospice Care.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, if the Covered Person has been diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less, and if the Company through a Case Manager gives Preauthorization, the Company will pay the Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Texas Department of Health or other appropriate state licensing agency and accepted by the Company as a Provider. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

3.19 **Oral Surgery.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Company will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.
2. Surgical procedures required to treat an Accidental Injury (See Subsection 9.1 Accidental Injury) to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered.
3. Excision of exostoses of jaws and hard palate.
4. External incision and drainage of abscess.
5. Incision of accessory sinuses, salivary glands or ducts.

See Section 3.31 Temporomandibular Joint Benefits.

3.20 **Dental Care or Orthodontic Services.** Dental Care and orthodontic services are not covered.

1. Benefits for Accidental Injury. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within 72 hours of injury or effective date of Coverage if injury occurred prior to coverage effective date for services to be covered. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

- a. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement
 - b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - c. Injury to teeth while eating is not considered an Accidental Injury.
 - d. Double abutments are not covered.
 - e. Any Health Intervention related to dental caries or tooth decay is not covered.
 - f. Removal of teeth is not covered.
2. Benefits for dental services. Dental services in connection with radiation treatment for cancer of the head or neck are covered.
 3. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in accordance with Subsection 3.3.3.

3.21 **Reconstructive Surgery. Cosmetic Services are not covered. (See Subsections 4.3.5 and 9.22)**

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a Physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person
2. Surgery performed to correct a Craniofacial Abnormality.
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.
4. In connection with a mastectomy eligible for coverage under this Benefit Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas lymphademas in a manner determined in consultation with the attending Physician and the Covered Person.
5. Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria is covered. 5

3.22 **Medications.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Prescription Medication. (See Subsection 9.95 Prescription Medication.) This coverage varies, depending upon the sites of service where the Medication is received by the Covered Person.

1. **Sites of Service**

- a. **Hospital or Ambulatory Surgical Center.** The benefit for Medications received from a Hospital or an Ambulatory Surgical Center is included in the Allowable Charge for the Hospital Services. See Subsections 3.2 and 3.3.
- b. **Physician's Office.** The benefit for Medications administered in a Physician's office is covered based upon the Allowable Charge for the Medication and subject to the Calendar Year Deductible and Coinsurance specified in the Schedule of Benefits. Conditions of coverage set forth in Subsections 3.22.2.a, b and c are applicable to this coverage.
- c. **Retail Pharmacy (Drug Store).** The benefit for Medications received from a licensed retail pharmacy is covered based upon the Allowable Charge for the Medication and subject to the Calendar Year Deductible and Coinsurance specified in the Schedule of Benefits.
 - i. **Covered Medications.** Generally, only A Medications are covered under this Subsection 3.22.1.c., however, a limited number of B Medications are covered under this Subsection 3.22.1.c. B Medications are covered under Subsections

- 3.22.1.a, b and d. (See Subsection 9.95 for definitions of “A Medications” and “B Medications.”)
- ii. **Administration Charges.** Charges to administer or inject any Medication are not covered under this Subsection 3.22.1.c.
 - iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.22.2. a, b, c, d and e are applicable to this coverage.
 - iv. **ID Card Presentation.** In order to receive benefits for a Prescription Medication under this Subsection 3.22.1.c, a Covered Person must present his or her US Able Mutual Insurance Company ID card to a Participating Pharmacy at the time the Covered Person purchases the Prescription Medication. (“Participating Pharmacy” is defined in Subsection 9.78.) The pharmacist will electronically notify the Company’s prescription benefits processor. The prescription benefits processor will electronically inform the pharmacist whether the Plan provides benefits for the Prescription Medication. If the prescription benefits processor indicates that the Plan does not provide benefits, the Covered Person may call the Pharmacy Help Line telephone number on the back of his or her ID card. If the Plan provides benefits, the pharmacist will charge the Covered Person the Calendar Year Deductible and Coinsurance specified in the Schedule of Benefits. Applicable Prescription Copayments are listed in Schedule of Benefits. The Company will only accept a post-purchase or paper claim for Prescription Medications purchased through a retail pharmacy (drug store) if such claim is submitted (1) for an Emergency Prescription, (2) for Prescription Medication purchased prior to the date the Covered Person received his or her US Able Mutual Insurance Company ID card or (3) in accordance with Subsection 3.22.1.c.v. below.
 - v. **Claim Submission.** The presentation of a Prescription to a pharmacist in accordance with this Subsection 3.22.1.c is not a claim for benefits under the terms of the Plan. However, a Covered Person may submit a claim if, upon such a presentation, the pharmacist informs the Covered Person that, because of the provisions of the Plan, the Plan has rejected benefits for the requested Prescription Medication. You may appeal an adverse benefit determination in connection with such Claim. See Subsection 7.1 Claim Processing and Subsections 7.2 and 7.3 Claim Appeals and Independent Medical Review of Claims.
 - vi. **Non-Participating Pharmacies.** Direct reimbursement will be necessary when purchasing a Prescription from a Non-Participating Pharmacy. In these cases, the Covered Person must pay for the Prescription at the time of purchase and submit a Prescription Claim Form. Deductible, Coinsurance and cost adjustments will be deducted from the reimbursement.
 - vii. **Medical Supplies.** Medical supplies such as, but not limited to, colostomy supplies, bandages and similar items are not generally covered under this Subsection 3.22.1.c; however, refer to Subsections 3.12 Medical Supplies and Subsection 3.22.1.d, below. Furthermore, subject to the terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided under this Subsection 3.22.1.c for insulin and syringes purchased at the same time as insulin and which are to be used for the sole purpose of injecting insulin. Syringes not meeting this standard are not covered. In addition certain blood glucose test meter supplies such as test strips and lancets are covered under the pharmacy benefit.
 - viii. **Immunizations.** Immunization agents and vaccines identified as preventive care vaccines for adults and children are covered when obtained at a retail pharmacy.
 - ix. **Durable Medical Equipment.** Durable Medical Equipment, even though such device may require a prescription, such as, but not limited to, therapeutic devices, artificial appliances, blood test glucose test meters, or similar devices, are not covered under this Subsection 3.22.1.c. Refer to Subsection 3.11

Durable Medical Equipment. However, certain blood glucose test meter supplies, such as test strips and lancets, are covered under the pharmacy benefit.

x. **Cost Sharing Information**

Each Prescription is covered only after the Covered Person pays the cost sharing indicated on the Covered Person's Schedule of Benefits, or the full cost of the drug, whichever is less, to the Participating Pharmacy. Covered Persons will be charged the appropriate cost sharing for each Prescription or refill. A refilled Maintenance Medication Prescription may be covered for up to a 3-month supply with cost sharing applied for each month's supply. (See Subsection 9.56 Maintenance Medication.)

When a Generic Medication is dispensed, the Covered Person will pay the second tier Medication cost sharing specified in the Schedule of Benefits for each initial and refill Prescription. If there is no generic equivalent, the Covered Person will pay the Brand Name Medication cost sharing, as applicable, for each initial and refill Prescription.

If a Brand Name Medication is dispensed when a Generic Medication is available, the Covered Person will pay the applicable Brand Name Medication cost sharing plus the difference in the cost of the Brand Name Medication and Generic Medication, or the cost of the medication, whichever is less. The difference paid between the Brand Name Medication and Generic Medication will not satisfy any cost sharing amounts.

xi. **Prescriptions, Excluded Providers.** Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.1.6.

d. **Home Infusion Therapy Pharmacy.** The benefit for Medications received from a licensed retail pharmacy designated by the Company as a home infusion therapy Provider is covered based upon the Allowable Charge for the Medication.

i. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics and hydration therapy.

ii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.22.2. a, b, c, d and e are applicable to this coverage.

iii. **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered under this Subsection 3.22.1.d. See Subsection 3.12. 20

iv. **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his/her scope of practice are covered under this Subsection 3.22.1.d. according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

2. **Conditions of Coverage**

a. **Preauthorization.** Selected Prescription Medications, as designated from time to time by the Company, are subject to Preauthorization through criteria established by the Company before coverage is allowed. Ongoing therapy of a prior authorized Medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy. A list of Medications for which Preauthorization is required is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.USABLEMUTUAL.COM. This Subsection 3.22.2.a. is applicable to Prescription Medication covered by Subsections 3.22.1.b, c. and d.

b. **Specialty Medications.** Selected Prescription Medications are designated by the Company as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined

handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Coverage for Specialty Medications is subject to Preauthorization and may only be purchased through a specialty pharmacy vendor under contract with the Company. The benefit for a Specialty Medication that is designated by the Company as "Specialty Medication 1" is subject to the Prescription Drug Copayment specified in the Schedule of Benefits. The benefit for a Specialty Medication that is classified by the Company as "Specialty Medication 2" is subject to the Calendar Year Deductible and Coinsurance specified in the Schedule of Benefits. A list of Specialty Medications is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.USABLEMUTUAL.COM. This Subsection 3.22.2.b is applicable to Prescription Medication covered by Subsections 3.22.1.b, c, and d.

c. **Formulary.** Except in limited circumstances set out in this Subsection 3.22.2.c. and elsewhere in this Benefit Certificate, a Prescription Medication must be listed in the Formulary in order to be covered. (See Subsection 9.40 Formulary.)

i. A list of Medications on the Formulary is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.USABLEMUTUAL.COM.

ii. If a Prescription Medication in the Formulary causes or has caused adverse or harmful reactions for a particular Covered Person, or has been shown to be ineffective in the treatment of a Covered Person's particular disease or condition, or if a Covered Person is engaged in a treatment plan using a Prescription Medication not in the Formulary when coverage begins, such Covered Person may be able to obtain coverage for a Prescription Medication not in the Formulary by requesting Preauthorization of an exception to USABLE Mutual Insurance Company Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203.

1. Standard Exception Request. If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 72 hours from the date it received the exception request or, in the event additional information is necessary, within 72 hours of receipt of the additional information. Any standard exception request for a Prescription Medication not in the Formulary will be approved for the duration of the prescription including refills.

2. Exception Request under Exigent Circumstances. An exception request for a Prescription Medication not in the Formulary will be considered in the event a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a Prescription Medication not in the Formulary. If the Company is able to process your request without requesting additional information (see Subsection 7.1.4.), it will notify you of its determination within 24 hours from the date it received the request, or, in the event additional information is necessary, within 24 hours of receipt of the additional information. Any exception request under exigent circumstances is approved for the duration of the exigency.

3. External Review of Denied Exception. If your request for either a standard exception to the Formulary or for an exception under exigent circumstances is denied, you may request an external review by an Independent Review Organization (see Subsection 7.4.4.). This request may be made by sending TDI Form LHL009, which is available

from the Company, marked "External Review Request" to the Appeals Coordinator of USABLE Mutual Insurance Company, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203. Alternatively, you may e-mail your request to APPEALSCOORDINATOR@USABLEMUTUAL.COM. A determination will be made on your appeal within 72 hours for a standard exception request or within 24 hours for an exception request under exigent circumstances. (See Subsection 7.4.9. regarding Notification of Determination.)

- iii. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will provide coverage for a Medication and its administration prescribed to treat a chronic, disabling or life-threatening illness so long as the Medication is approved by the United States Food and Drug Administration for at least one indication and the Medication is recognized to treat such illness by a prescription drug reference compendium approved by the Texas Insurance Commissioner or is substantially accepted in peer-reviewed medical literature.
 - iv. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will provide coverage for orally administered anticancer medications on a basis no less favorable than intravenously administered or injected cancer medications covered by the Plan.
 - v. Finally, if a Covered Person requests, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will continue to provide the Covered Person Medication(s) that were covered by the Plan, at the contracted benefit level until the next Plan renewal date, regardless of whether the Medication has been removed from the Formulary. This Subsection 3.22.2.c is applicable to Prescription Medication covered by Subsections 3.22.1. b., c. and d.
- d. **Step Therapy.**
- i. Selected Prescription Medications as designated from time to time by the Company, are subject to Step Therapy restrictions. (See Subsection 9.114 Step Therapy.) Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. The Step Therapy requirements for a particular Prescription Medication are available from the Company upon request. This Subsection 3.22.2.d is applicable to Prescription Medication covered by Subsections 3.22.1. c. and d.
 - ii. Your prescribing provider may request an exception to the Step Therapy restrictions in writing and accompanied by supporting documentation when: (1) the Prescription Medication required under Step Therapy is contraindicated, will likely cause an adverse reaction in or physical or mental harm to the Covered Person, or is expected to be ineffective based on known clinical characteristics of the Covered Person and the Prescription Medication; (2) the Covered Person previously discontinued taking the Prescription Medication required under Step Therapy or another Prescription Medication in the same pharmacologic class or with the same mechanism of action as the required Prescription Medication while covered by a health benefit plan because the Prescription Medication was not effective or had a diminished effect or because of an adverse event; (3) the Prescription Medication required under Step Therapy is not in the best interest of the Covered Person based on clinical appropriateness; or (4) the Covered Person is stable on the current Prescription Medication prescribed for the Covered Person's condition under Step Therapy and the change to the Covered Person's Prescription Medication required under Step Therapy is expected to be ineffective or cause harm to the Covered Person based on known clinical characteristics of the required prescription drug regimen. If an exception request is not denied within seventy-two (72) hours, it is deemed to be granted except in the event that the prescriber believes that denial of the

exception request makes the death of or serious harm to the Covered Person probable, in which case if the exception request is not granted within twenty-four (24) hours, it shall be deemed granted. A denial of a step therapy exception request is considered an adverse determination subject to expedited appeal. (see Subsection 7.3.9).

e. **Limitations**

- i. **Dispensing Quantities.** Coverage for a Prescription Medication is limited to any quantity or period authorized by the prescribing Physician or health care Provider. New Prescriptions are for up to a month's supply of medication in accordance with the cost sharing set out in your Schedule of Benefits. After the first month's prescription of certain Maintenance Medications, your Prescription may be covered for up to a 3-month supply with cost sharing applied for each month. Early refills are covered subject to the Company's approval except in the event of an active Medication Synchronization Plan (see Subsection 3.22.2.e.iii. below). A prescription will not be covered if refilled after one year from the original date of the Prescription.
- ii. Coverage of selected Prescription Medications as designated from time to time by the Company is subject to Dose Limitations. (See Subsection 9.33 Dose Limitation.) The Dose Limitation for a particular Prescription Medication is available from the Company upon request. This Subsection 3.22.2.e is applicable to Prescription Medication covered by Subsections 3.22.1. c. and d.
- iii. **Medication Synchronization Plan.** Early refills of medications are generally not covered, however, early refills of certain medications for chronic illnesses will be allowed in accordance with a medication synchronization plan agreed to by the Plan, the Covered Person, the prescribing Physician or health care provider and a pharmacist. Early refills due to an approved medication synchronization plan are subject to prorated cost sharing amounts.

- f. **Modification of Drug Coverage.** The Formulary is reviewed quarterly by the Pharmacy and Therapeutics Committee to evaluate any necessary modifications to drug coverage. Modification of coverage for Medications, including removing of a Medication from the Formulary; adding a Preauthorization requirement; imposing or altering a quantity limit for a Medication; imposing a step-therapy restriction on a Medication; or moving a Medication to a higher cost-sharing tier unless a generic alternative to the Medication is available, shall not occur unless:
- i. the modification occurs at the time of coverage renewal;
 - ii. the modification is effective uniformly among all individuals covered by identical or substantially identical health benefit plans to the Plan; and
 - iii. the modification becomes effective no earlier than the sixtieth (60th) day after the Company provided notice of the modification to the Texas Insurance Commissioner, to each affected group health benefit plan sponsor and to each Covered Person affected by the modification.

3.23 **Organ Transplant Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

1. Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Benefit Certificate.
2. Except for kidney and cornea transplants, coverage for transplant services requires Preauthorization by the Company. A request for approval must be submitted to the Company prior to receiving any transplant services, including transplant evaluation. **Please note that Preauthorization does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the transplant meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any transplant receiving Preauthorization, must still meet all other coverage terms,**

conditions, and limitations, and coverage for any transplant receiving Preauthorization may still be limited or denied if, when the claims for the transplant are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.

3. The transplant benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.
4. Notwithstanding any other provisions of this Benefit Certificate, at the option of the Company, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by an in-network center of excellence transplant facility we offered to the Covered Person, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility outside of network, the Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of an amount equaling the lesser of (a) ninety (90%) percent of billed charges or (b) the global payment determined as payment in full by the in-network center of excellence transplant facility we offered to the Covered Person. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the network, that facility has agreed to accept the global payment as payment in full, and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**
5. When the Covered Person is the potential transplant recipient, a living donor's hospital costs for the removal of the organ are covered with the following limitations:
 - a. Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less;
 - b. Donor testing is covered only if the tested donor is found compatible; and
 - c. To the extent that benefits remain and are available under the Plan, after the Covered Person's expenses have been paid. In the event of such coverage, the otherwise existing coverage of the Donor shall be secondary to the benefits under the Plan.
6. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission. A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.
7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

3.24 **Preventive Health Services**

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Company will pay one hundred percent (100%) of the Allowable Charges for the routine

preventive health services listed below when provided by a Preferred Provider Physician. However, for services received by Non-Preferred Provider Physicians, the Company will pay benefits subject to the appropriate Deductible and Coinsurance as listed in the Schedule of Benefits.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Examples of current recommendations for preventive services include but are not limited to routine exams for children and adults, breast cancer screenings, PSA's and prostate exams, colorectal cancer screenings and osteoporosis screenings. Examples of current recommendations for immunizations include but are not limited to, diphtheria, pertussis, poliomyelitis, measles, mumps, rubella, varicella, and hepatitis B. Please visit WWW.USABLEMUTUAL.COM to access links for updates or changes to the current recommendations or feel free to contact us at 1-800-519-2583 for further information.

6. Annual routine gynecological examination including certain tests for the detection of human papillomavirus (HPV), cervical cancer, and ovarian cancer.
 - a. Coverage required under this section includes at a minimum a CA 125 blood test, and a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus (HPV).
 - b. A Screening Test required under this section must be performed in accordance with the guidelines adopted by (1) the American College of Obstetricians and Gynecologists; or (2) another similar national organization of medical professionals recognized by the Insurance Commissioner of Texas.
7. Routine mammography annually after age 35.
8. Routine Diagnostic Examination for the Detection of Prostate Cancer
 - a. Routine physical examination for the detection of prostate cancer; and
 - b. Prostate-specific antigen test used for the detection of prostate cancer.This benefit is payable annually to each covered male who is: (a) at least 50 years of age and asymptomatic; or (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.
9. Children's Preventive Health Care Services, subject to the following limitations:
 - a. Covered services are limited to age appropriate medical history; physical examination, including routine tests and procedures to detect abnormalities or malfunction of bodily systems and parts: developmental assessment; anticipatory guidance; appropriate Childhood Immunizations, and Laboratory tests. There is no Deductible or Coinsurance applied to Childhood Immunizations.
For the purposes of this benefit, a Child is covered for Childhood Immunizations from their date of birth through eighteen (18) years of age.
 - b. Coverage is limited to not more than twenty (20) visits.
 - c. Hearing loss Screening Tests from the date of birth through the date the Child is 30 days old and necessary diagnostic follow-up care related to such Screening Tests from birth through the date the Child is 24 months old.
10. Routine Diagnostic Examination for the Detection of Colorectal Cancer

- a. Screening examination and medical procedures for each Covered Person who is 50 years of age or older.
 - b. Benefits include:
 - i. a fecal occult blood test performed annually; and
 - ii. a flexible sigmoidoscopy performed every five years or a colonoscopy performed every 10 years.
 - c. Routine Diagnostic Examination for the Detection of Colorectal Cancer is subject to the Deductible and Coinsurance as stated in the Schedule of Benefits.
11. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, coverage is provided for up to \$200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years: (1) computed tomography (CT) scanning measuring coronary artery calcification or (2) ultrasonography measuring carotid intima-media thickness and plaque. This coverage is provided to each Covered Person who is a male older than 45 years of age and younger than 76 years of age or a female older than 55 years of age and younger than 76 years of age, and who is diabetic or has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.
12. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, coverage is provided for medically accepted bone mass measurement to detect low bone mass and to determine the Covered Person's risk of osteoporosis and fractures associated with osteoporosis.

3.25 **Medical Foods and Low Protein Modified Food Products.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Covered Person diagnosed with phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism if:

- 1. the Medical Foods and Low Protein Modified Food Products are administered under the order of a licensed Physician; and
- 2. the Medical Foods and Low Protein Food Modified Products are prescribed in accordance with Coverage Policy for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism.

This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits. However, any services or supplies provided for dietary and nutritional services, unless such services or supplies are the sole source of nutrition for the Covered Person, are not covered. See Subsection 4.3.28.

3.26 **Amino Acid-Based Elemental Formulas.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- 1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- 2. severe food protein-induced enterocolitis syndrome;
- 3. eosinophilic disorders, as evidenced by the results of a biopsy; and
- 4. impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

This benefit is subject to a written order issued by the treating physician and shall be provided on a basis no less favorable than the basis on which prescription drugs and other medications and related services are provided for Medications. See Subsection 3.22.

3.27 **Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate coverage is provided for Prenatal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

3.28 **Complications from Smallpox Vaccine.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for complications

resulting from a smallpox vaccination. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

- 3.29 **Autism Spectrum Disorder.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for screening a covered Child for autism spectrum disorder at the ages of 18 and 24 months. Additionally, coverage is provided to a Covered Person who is diagnosed with autism spectrum disorder from the date of diagnosis.
- 3.30 **Acquired Brain Injury.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for a medical intervention in connection with an Acquired Brain Injury. Coverage includes services for Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing or Treatment, Neurofeedback Therapy, Remediation, Post-acute Transition Services or Community Reintegration Services.
- 3.31 **Temporomandibular Joint Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Medical treatment shall include diagnostic treatment as well as surgical and nonsurgical procedures. Coverage is subject to the Deductible and Coinsurance listed in the Schedule of Benefits. Dental services are not covered except in accordance with Section 3.20 Dental Care or Orthodontic Services.
- 3.32 **Miscellaneous Health Interventions.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this benefit certificate, coverage is provided for the following:
1. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.2.14. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.
 2. **Clinical Trials.** Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. See Subsection 4.3.3. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Routine Patient Costs for items and services furnished in connection with participation in the clinical trial are covered, provided the Covered Person is eligible to participate and has been approved for participation in accordance with the protocols of the clinical trial and the clinical trial is an Approved Clinical Trial. See Subsection 4.3.3.
 3. **Contraceptive Devices.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for contraceptive devices when prescribed by a Physician.
 4. **Dietary and Nutritional Counseling Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, and subject to the Deductible, and Coinsurance specified in the Schedule of Benefits, coverage is provided for dietary and nutritional counseling services when provided in conjunction with Diabetic Self-Management Training, for services needed by Covered Persons in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by the Company.
 5. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.2.33. However, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
 6. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.2.35. However, enteral feedings are covered when such feedings have been approved and documented by a Physician as being the Covered Person's sole source of nutrition.

7. **High Frequency Chest Wall Oscillators.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided, to Covered Persons with cystic fibrosis, for one high frequency chest wall oscillator during such Covered Person's lifetime.
8. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.2.55. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, where the patient is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
9. **Trans-telephonic Home Spirometry.** Trans-telephonic home or ambulatory spirometry is not covered. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, trans-telephonic home spirometry is covered for patients who have had a lung transplant.
10. **Vision enhancement.** Vision enhancements are generally not covered, see Subsection 4.2.100. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye are covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after a cataract extraction, the Plan will pay the Allowable Charge for a monofocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.11.4.

4.0 SPECIFIC PLAN EXCLUSIONS

Even if the Primary Coverage Criteria (See Section 2.0) are met, coverage of a particular service, supply or condition may not be covered under the terms of this Benefit Certificate. This Section 4.0 describes the conditions, Provider services, health interventions and miscellaneous fees or services for which coverage is excluded.

4.1 Health Care Providers.

1. **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Residential long term care facilities for mental health or eating disorders are not covered. Youth homes, boarding schools, or any similar institution are not covered.
2. **Freestanding Cardiac Care Facility.** Treatment received at a Freestanding Cardiac Care Facility is not covered.
3. **Immediate Relatives.** Professional services performed by a person who ordinarily resides in the Covered Person's home, including self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
4. **Midwives, Not Certified.** Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.
5. **Physical Therapy Aide.** Services or supplies provided by a physical therapy aide are not covered.
6. **Provider, Excluded.** Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.
7. **Provider, undefined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Benefit Certificate are not covered. (See Subsection 9.44 Health Care Provider and 9.79 Physician.)

8. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
9. Residents, interns, students or fellows. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.
10. Unlicensed Provider. Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of the Company's Medical Director, include within its scope the treatment, procedure or service provided.

4.2 **Health Interventions.**

1. Abortion. Abortion is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.
2. Abuse of Medications. Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered.
3. Acupuncture. Acupuncture and services related to acupuncture are not covered.
4. Adoptive Immunotherapy. Adoptive immunotherapy, (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy, autolymphocyte therapy (ATL)) is not covered.
5. Antigen immunotherapy. Antigen immunotherapy for repeat fetal loss is not covered.
6. Arthroereisis for Pes Planus (Flat Feet). This treatment is sometimes used to treat flat feet and is not covered.
7. Balloon Sinuplasty. A balloon sinuplasty device is sometimes used for treatment of sinusitis and is not covered.
8. Behavior/conduct disorders. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders or neuroeducational testing are not covered.
9. Bereavement services. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
10. Biochemical Markers for Alzheimer's Disease. Measurement of cerebrospinal fluid and urinary biomarkers of Alzheimer's disease including but not limited to tau protein, amyloid beta peptides and neural thread proteins are not covered.
11. Biofeedback. Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition; however, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Neurofeedback Therapy in connection with an Acquired Brain Injury. See Subsections 3.30, 9.2 and 9.66.
12. Blood Typing. Blood Typing or DNA analysis for paternity testing is not covered.
13. Bone Growth Stimulation, electrical, as an adjunct to cervical fusion surgery. Electrical Bone Growth Stimulation used as an adjunct to cervical fusion surgery is not covered.
14. Chelation therapy. Services or supplies provided as, or in conjunction with, chelation therapy, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered. See Subsection 3.32.1.
15. Chemical Ecology. Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
16. Combination therapy for treatment of hepatitis C--When Sofosbuvir (Sovaldi) is used in combination with other Direct Antiviral Agents such as Incivek (telaprevir), Victrelis (Boceprevir) or Olysio (simeprevir) to treat hepatitis C, both drugs are excluded from benefits. Sovaldi and Olysio are only covered as agents for treatment of specific hepatitis C genotypes when

- combined with Ribavirin and/or PegINF and criteria listed in the related published Coverage Policy is met.
17. Cognitive Communication Therapy. Services or supplies provided as or in conjunction with, Cognitive Communication Therapy are not covered, however, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Cognitive Communication Therapy in connection with an Acquired Brain Injury. See Subsections 3.30 and 9.16.
 18. Cold Therapy. Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.
 19. Compound Medications Except for compounded morphine, Compound Medications are not covered.
 20. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment or service not covered under this Policy are not covered.
 21. Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this document, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.
 22. Cord Blood. The collection and/or storage of cord or placental blood cells for an unspecified future use as an autologous stem-cell transplant in the original donor or for some other unspecified future use as an allogeneic stem-cell in a related or unrelated donor is not covered.
 23. Coverage Policy. The Company has developed and published on its website specific Coverage Policies in relation to certain Health Interventions. If a Coverage Policy exists for an Intervention, the Coverage Policy shall determine whether such Intervention meets the Primary Coverage Criteria. If a Coverage Policy determines that a Health Intervention does not meet the Primary Coverage Criteria, this Plan does not provide coverage for that Intervention. The absence of a specific Coverage Policy with respect to any particular Health Intervention should not be construed to mean that the Intervention meets the Primary Coverage Criteria.
 24. Cranial electrotherapy or cranial electromagnetic stimulation devices. Cranial electrotherapy or electromagnetic stimulation devices are not covered.
 25. Current Perception Threshold Testing. This testing performed as a substitute for standard nerve conduction studies in diagnosing carpal tunnel or tarsal tunnel syndrome is not covered.
 26. Dental Care or orthodontic services. Dental Care and orthodontic services are not covered.
 1. Benefits for Accidental Injury. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within 72 hours of injury for services to be covered. Coverage is subject to the Deductible and Coinsurance specified in the Schedule of Benefits with the following limitations:
 - i. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
 - ii. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - iii. Injury to teeth while eating is not considered an Accidental Injury.
 - iv. Double abutments are not covered.
 - v. Any Health Intervention related to dental caries or tooth decay is not covered.
 - vi. Removal of teeth is not covered.

2. Benefits for dental services. Dental services in connection with radiation treatment for cancer of the head or neck are covered.
3. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental or orthodontic procedures, including services to children, are covered in accordance with Subsection 3.2.3.
27. Dietary and Nutritional Services. Any services or supplies provided for Dietary and Nutritional Services, unless such services or supplies are the sole source of nutrition for the Covered Person, are not covered. Baby formula or thickening agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism. See Subsection 3.25.
28. Digitization Computer Enhanced X-ray Analysis for Spinal Evaluation. Spinal visualization using digitization of spinal x-rays and computerized analysis of the back or spine is not covered.
29. Dynamic Orthotic Cranioplasty. Dynamic orthotic cranioplasty is not covered.
30. Dynamic spinal motion visualization techniques such as Digital Motion X-ray, Cineradiography and Videoradiography. The use of digital motion x-ray for the evaluation of musculoskeletal conditions is not covered.
31. EKG, Signal Averaged. Signal averaged electrocardiography utilized to stratify risk for arrhythmias following myocardial infarction, in patients with cardiomyopathy, in patients with syncope, as an assessment of success after surgery for arrhythmia, in detection of acute rejection of heart transplants, as an assessment of efficiency of antiarrhythmic drug therapy and in the assessment of successful pharmacological, mechanical or surgical Interventions to restore coronary blood flow is not covered.
32. Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.
33. Enhanced External Counterpulsation. Enhanced external counterpulsation (EECP) is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for one course of enhanced external counterpulsation for the treatment of disabling angina in patients who are NYHA Class III or IV, or equivalent classification; who have experienced inadequate control of anginal symptoms with a medication regimen that consists of optimal dosages of platelet inhibitors, beta-blockers, calcium channel blockers, long-acting nitrates, lipid-lowering drugs and antihypertensives when these drugs are appropriate and there is no contraindication to any of these drugs; and who are not amenable to surgical cardiac intervention such as angioplasty or coronary artery bypass grafting. Repeat courses of EECP are not covered.
34. Enteral Feedings. Enteral feedings are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Covered Person's sole source of nutrition with Preauthorization by Case Management.
35. Environmental Intervention. Services or supplies used in adjusting a Covered Person's home, place of employment or other environment so that it meets the Covered Person's physical or psychological condition are not covered.
36. Epiduroscopy/spinal myelotomy. This service is used in the diagnosis and treatment of spinal pain and is not covered.

37. Excessive Use. Excessive use of Medications is not covered. For purposes of this exclusion, each Covered Person agrees that the Company shall be entitled to deny coverage of medications on grounds of excessive use when the Company's medical director determines (1) that a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) that a Covered Person has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3) that the pattern of Prescription purchases, changes of Physicians or pharmacy or other information indicates that a Covered Person has obtained or sought to obtain excessive quantities of Medications. Each Covered Person hereby authorizes the Company to communicate with any Physician, health care Provider or pharmacy for the purpose of reviewing and discussing the Covered Person's Prescription history, use or activity to evaluate for excessive use.
38. Exercise programs. Exercise programs for treatment of any condition are not covered.
39. Extracorporeal Shock Wave Therapy. Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
40. Family Planning. The following family planning services are not covered.
- a. reversal of sterilization
 - b. preimplantation
 - c. surrogate mothers providing services for a Covered Person.
 - d. treatment of infertility.
 - e. in vitro fertilization.
41. Foot care. Non-custom shoe inserts are not covered. Services or supplies for the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate foot care is provided when required for prevention of complications associated with diabetes mellitus.
42. Fraud or Material Misrepresentation. Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the ID card or by material misrepresentation are not covered.
43. Free Health Interventions. Health Interventions, including but not limited to Medications, provided or dispensed without charge to the Covered Person or for which, normally (in professional practice), there is no charge, are not covered.
44. Genetic testing. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Covered Person's blood or tissue to determine if the Covered Person has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Policy, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Company has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Company will determine which particular genetic tests may be eligible for benefits as an exception to this exclusion. Any published Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

45. Hair loss or growth. Wigs, hair transplants or any Medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
46. Hearing devices or talking aids. Regardless of the reason for the hearing or speech disability, Prosthetic devices to assist hearing (except for hearing aids as covered for Covered Persons under the age of 19), or talking devices including special computers are not covered. The testing for, the fitting of, or the repair of, such hearing aids and Prosthetic devices to assist hearing; or talking devices is not covered. However, subject to all terms, conditions, exclusions, and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for:
 - a. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor, including fitting and dispensing services, up to a lifetime maximum benefit of one cochlear implant per ear per Covered Person. For Covered Persons 18 years of age or younger, coverage is provided for internal replacement when medically or audiological necessary and for treatment for habilitation and rehabilitation services as necessary for educational gain; and
 - b. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors and
 - c. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear, subject to Preauthorization. Coverage is further limited to Covered Persons with
 - i. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
 - ii. chronic external otitis or otitis media;
 - iii. tumors of the external canal and/or tympanic cavity; and
 - iv. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.
47. Heat Bandage. Treatment of a wound with a Warm-up Active Wound Therapy device or a noncontact radiant heat bandage is not covered.
48. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered except in accordance with the Company's specific Coverage Policies. See Subsection 3.23.
49. Hippo Therapy. Hippo therapy is not covered.
50. Home delivery. Services and supplies received in connection with child birth in the home are not covered regardless of the Provider.
51. Home Uterine Activity Monitor. Home uterine activity monitors or their use is not covered.
52. Hypnotherapy. Hypnotherapy is not covered for any diagnosis or medical condition.
53. Illegal Uses. Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered.
54. Inotropic Agents for Congestive Heart Failure. Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, where the patient is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
55. Interspinous Distraction Devices (Spacers). These devices are inserted between the spinous processes, and they act as a spacer between the spinous processes. Their proposed use is to treat leg and/or back pain secondary to spinal stenosis and distract the spinous processes and restrict extension. Interspinous Distraction Devices (Spacers) are not covered. Examples include, but are not limited to, the X-STOP interspinous Process by Medtronic, the Wallis System by Abbott Spine, the Coflex implant by Paradigm Spine, the ExtendSure and CoRoent

- devices by NuVasive, the NL-Prow by NonLinear Technologies, the Aperius by Medtronic Spine.
56. Intraoperative Neurophysiologic Monitoring, Remotely Performed. Intraoperative neurophysiologic monitoring is used to monitor the integrity of neural pathways during high-risk neurosurgical, orthopedic and vascular surgeries. It is not covered when performed from a remote location. The physician performing this service must be a licensed physician (other than the operating surgeon or the performing anesthesiologist) and be physically present in the operating room. When intraoperative monitoring is remotely performed it is not covered.
 57. Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders. Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
 58. Learning Disabilities. Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
 59. Lost Medications. Replacement of previously filled Prescription Medications because the initial Prescription Medication was lost, stolen, spilled, contaminated, etc. are not covered.
 60. Maintenance Therapy. Maintenance Therapy is not covered. (See Subsection 9.55.)
 61. Measurement of Exhaled Nitric Oxide. Measurement of Exhaled Nitric Oxide used in the diagnosis and management of asthma and other respiratory disorders is not covered.
 62. Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2). Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2), also known as platelet-activating factor acetylhydrolase is not covered. The proposed use of this test is to assess cardiovascular risk.
 63. Measurement of Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease. Measurement of novel lipid risk factors including but not limited to apolipoprotein B, apolipoprotein A-1, HDL subclass, LDL subclass, apolipoprotein E, and Lipoprotein A are not covered.
 64. Measurement of Serum intermediate Density Lipoproteins (remnant-like particles). These lipoproteins have a density that falls between low density lipoproteins and very low density lipoproteins. Measurements of these "remnant-like" particles are not covered.
 65. Medical Supplies. Medical Supplies that can be purchased without a prescription, whether or not a prescription was obtained, are not covered; for example, medication coated dressings, tape and gauze are not covered even with a Physician's Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. See Subsection 3.12 Medical Supplies, Subsection 3.14 Diabetes Treatment and Section 3.17 Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.
 66. Medication Therapy Management Services. Medication therapy management services by a pharmacist, including but not limited to a review of a Covered Person's history and medical profile, an evaluation of Prescription Medication, over-the-counter medications and herbal medications, are not covered.
 67. Mobile Cardiac Outpatient Telemetry (MCOT). Mobile Cardiac Outpatient Telemetry is sometimes used in patients who experience infrequent symptoms suggestive of cardiac arrhythmias. MCOT is not covered.
 68. Naturopath/Homeopath Treatment. Naturopathic or Homeopathic treatments of any condition are not covered.
 69. Neural Therapy. Neural therapy often involves the injection of a local anesthetic into scars, trigger points, acupuncture points, tendon insertions, ligament insertions, peripheral nerves, autonomic ganglia, the epidural space and other tissues to treat chronic pain and illness. Neural therapy is not covered.
 70. Neurofeedback. The proposed use of Neurofeedback has been to reinforce neurobehavior modification in patients with certain neurological and/or neurobehavioral disorders such as ADD, ADHD, Parkinson's Disease, epilepsy, insomnia, depression, mood disorders, post-

traumatic stress disorder, alcoholism, drug addiction, menopausal symptoms and migraine headaches. Neurofeedback is not covered.

71. Off-Label Use. (a) Except as provided in subsection (b) or (c) of this subsection, Prescription Medications and devices that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. (b) From time to time a particular clinical use of a Prescription Medication may be determined to be safe and efficacious by the Company's medical director, managed pharmacy director, or the Pharmacy and Therapeutics Committee, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the Medical Literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Preauthorization is often (but not always) required. Other than the list of Medications requiring Preauthorization cited above, a complete list of Medications and their approved off-label indications is not available. (c) A Prescription Medication approved by the FDA for the treatment of cancer, though not approved to treat the specific cancer for which it has been prescribed, will be covered provided:
 1. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as "not indicated" or otherwise inappropriate or not recommended, in one or more such compendia: (A) The American Hospital Formulary Service Drug Information or (B) The United National Comprehensive Cancer Network Drugs and Biologics Compendium; (C) The Elsevier Gold Standard's Clinical Pharmacology; or
 2. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from Medical Literature that have not had their recognition of the Prescription Medication's safety and effectiveness contradicted by clear and convincing evidence presented in another article from Medical Literature; or
 3. other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services may be used to provide coverage.
72. Oral, Implantable and Injectable Contraceptives. Oral, implantable and injectable contraceptive drugs, and Prescription barrier methods that are not on the Formulary are not covered.
73. Orthoptic, Pleoptic or Vision Therapy. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Benefit Certificate, coverage is provided in the following instances: 1.) office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities.
74. Over the Counter Medications. Medications (except insulin) which do not by law require a Prescription from a Physician are not covered.
75. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.
76. Percutaneous discectomy and radio-frequency thermocoagulation. Any method of percutaneous discectomy, including, but not limited to, automated or manual percutaneous discectomy, laser discectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.
77. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.
78. Prolotherapy. Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
79. Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions. The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
80. Rest cures. Services or supplies for rest cures are not covered.
81. Reversal of any sterilization procedure. Services related to the reversal of any sterilization procedure regardless of the reason for the sterilization are not covered.

82. Seasonal Affective Disorder (SAD). Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
83. Sensory Stimulation for Coma Patients. Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
84. Sexual Enhancement Medications. Medications used for the treatment of sexual dysfunction, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.
85. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for Laboratory documented growth hormone deficiency, are not covered.
86. Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.
87. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products not on the Formulary, including, but not limited to, nicotine gum and nicotine patches are not covered.
88. Snoring. Devices, procedures or supplies to treat snoring are not covered.
89. Spinal Manipulation under general anesthesia. This type of manipulation is sometimes used for treatment of arthrofibrosis of the knee or shoulder and is intended to overcome the patient's protective reflex mechanism. Spinal manipulation under anesthesia is not covered.
90. Spinal Uploading Devices for treatment of low back pain. Spinal uploading devices including, but not limited to, gravity dependent and pneumatic devices are not covered. Examples include, but are not limited to, the Orthotrac Pneumatic Vest and other thoracic-lumbar-sacral orthotics which provide trunk support.
91. Substance Addiction. Medications used to sustain or support an addiction or substance dependency are not covered. However, the use of designated agonists (e.g. methadone or buprenorphine) as part of a comprehensive substance abuse treatment plan are covered.
92. Tanning equipment or salon. The purchase or rental of tanning equipment or the services of a tanning salon are not covered.
93. Thermography. Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
94. Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae. Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
95. Transplant procedures. The following transplant procedures and services are not covered:
 - a. Solid organ transplants of any kind are not covered for a Covered Person with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. Exceptions to this non-coverage are (i) hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma, and (ii) basal cell and squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
 - b. Organ transplants not authorized by Coverage Policy are not covered.
96. Total Facet Arthroscopy. Facet arthroscopy refers to the implantation of a spinal prosthesis to restore posterior element structure and function as an adjunct to neural decompression surgery.

Total Facet Arthroscopy is not covered. Examples of facet arthroplasty devices include, but are not limited to, the ACADIA facet replacement System, the Total Facet Arthroscopy System and the Total Posterior-element System (TOPS).

97. Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.
98. Viscosupplementation for treatment of Osteoarthritis. Intra-articular hyaluronan such as Synvisc, Hyalgan, Supartz, Orthovisc and Euflexxa are not covered when used to treat osteoarthritis of any joint other than the knee (e.g. the hip).
101. Vision enhancement. Any procedure, treatment, service, equipment or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and Refractive Keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to an Allowance or Allowable Charge. Please contact Customer Service to inquire about the Allowance or Allowable Charge for eyeglass frames. See Subsection 3.11.4.
102. Vitamins or Baby Formula. Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism. See Subsection 3.25.
103. Vocational rehabilitation. Vocational rehabilitation services, vocational counseling and testing, employment counseling or services to assist a Covered Person in gaining employment, are not covered.
104. Weight Control. Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss or dietary control are not covered. Weight loss surgical procedures, including complications and effects relating thereto and any concomitant surgical procedures, including, but not limited to, hiatal hernia repairs, are not covered.
105. Whole body computed tomography. Whole body computed tomography is not covered.
106. Wound Treatment. Blood derived growth factors are not covered.

4.3 **Miscellaneous Fees and Services.**

1. Administrative Fees. Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.
2. Appointments. Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.
3. Clinical Trials. Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for routine patient care provided in connection with a clinical trial where such coverage would be provided without regard to the clinical trial.
4. Comfort items. Personal hygiene or comfort items including but not limited to, tub stool or chair, spray nozzle, heating pad, heating lamp, hot water bottle, ice cap, television, radio, telephone,

guest meals, whirlpool bath, adjustable bed, automobile/van conversion or addition of patient lifts, hand control, or wheel chair ramp, and home modifications such as overhead patient lift and wheelchair ramps are not covered.

5. Cosmetic Services. All services or procedures related to or complications resulting from Cosmetic Services are not covered even if coverage was provided through a previous carrier.
6. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by this Benefit Certificate are not covered.
7. Custodial Care. Services or supplies for custodial, convalescent, domiciliary or supportive care and non-medical services to assist a Covered Person with activities of daily living are not covered. (See Subsection 9.28, Custodial Care.)
8. Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.
9. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Covered Person acts as the donor are not covered except for Autologous services.

When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:

- a. Allowable Charges for the organ removal as well as any complications resulting from the organ removal are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
 - b. Services for testing of a donor who is found to be incompatible are not covered.
10. Education Programs. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Diabetes Self-Management Training. See Subsection 3.14.
 11. Excess charges. The part of an expense for care and treatment of an illness or Accidental Injury that is in excess of the Allowable Charge is not covered.
 12. Postage or Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.
 13. Prescription Medications used in connection with Health Interventions Not Covered by Plan. Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not covered under this Benefit Certificate, or for which this Benefit Certificate's benefits have been exhausted, are not covered.
 14. Services Received Outside the United States. Services or supplies received outside of the United States of America shall not be covered except when approved by the Company.
 15. Telephone and Other Electronic Consultation. Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Benefit Certificate,
 - a. Coverage is provided for Telemedicine and Telehealth services performed by a Physician licensed to practice medicine in the state of Texas and operating with his or her own license, at the same rate as if it had been performed in person.
 - b. However, Telemedicine and Telehealth services provided by only synchronous or asynchronous audio interaction or via text-only communication, including, but not limited to, an audio-only telephone consultation, a text-only email or SMS message, or a facsimile transmission, are not covered.
 - c. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers are covered.
 16. Travel or accommodations. Travel or transportation as a treatment or to receive consultation or treatment except Ambulance Services covered under Subsection 3.15 are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.

17. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.
18. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Covered Person filed a claim for workers' compensation benefits in a timely manner. See Subsection 5.3 Other Plans and Benefit Programs.

5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES

The plan may afford you significant savings if you obtain coverage from Providers who are members of our Preferred Provider Organization ("Preferred Providers"). This Section explains how you can maximize your benefits under the Plan by using Preferred Providers, see Subsection 5.1. Under your plan, you are responsible for part of the costs associated with covered services, supplies, equipment and treatment. Your responsibilities are explained in this Section, see Subsection 5.2. Finally, this Section explains how costs of benefits that are covered by another benefit plan are covered by the Plan, see Subsection 5.3.

5.1 Network Procedures

1. **Standard Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for Health Interventions you receive from a Health Care Provider or a Physician as defined in this Plan. See Subsections 9.44 and 9.79.
2. **Preferred Provider Organization (PPO).** This coverage is most effective and advantageous for you when the services of Preferred Providers are used. Claims associated with services provided by Preferred Providers may have a more advantageous Deductible, Coinsurance and Calendar Year Coinsurance Maximum than claims for services of Non-Preferred Providers. For the definitions and explanation of the terms "Deductible," "Coinsurance," and "Calendar Year Coinsurance Maximum" please refer to Section 9.0 Glossary of Terms and Subsection 5.2.

The PPO or In-Network Deductible, Coinsurance and Calendar Year Coinsurance Maximum set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Preferred Provider, unless the Schedule of Benefits or this Benefit Certificate shows a different Deductible, Coinsurance or Calendar Year Coinsurance Maximum for the particular service.

3. **List of Preferred Providers.** A list of Preferred Providers in the PPO Service Area is available to the Employee at the time his coverage becomes effective. The list of Preferred Providers will be updated annually. The Company or your Employer can provide a list of Preferred Providers. You may also obtain a list of Preferred Providers on the Company's web site WWW.USABLEMUTUAL.COM.
4. **Provider Status may Change.** It is possible that you might not be able to obtain services from a particular Preferred Provider. The network of Providers is subject to change. You might find that a particular PPO Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another PPO Provider to get In-Network benefits.
5. **Notice of Termination of a Preferred Provider.** The Company will give reasonable advance notice of a Preferred Provider's termination and provide Covered Persons affected by the termination with a current list of Preferred Providers.
6. **Continuity of Care.** Termination of a Preferred Provider will not release the Provider from treating a Covered Person and cooperating in arranging for appropriate referrals except in the event the termination was for reasons of medical competence or professional behavior.

If a terminating provider is treating a Covered Person with Special Circumstances such as a disability, acute condition or Life-Threatening Illness or is past the 24th week of pregnancy, the provider may continue treating the Covered Person if they submit a request to the Company. The request must identify the Special Circumstances.

If the Company agrees to the continued treatment, the Company will continue to reimburse the terminating provider and the Covered Person at the Preferred Provider level of benefits. The provider may not seek payment from the Covered Person for any amounts for which a Covered Person would not be responsible if the provider were still a Preferred Provider. Reimbursement at the Preferred Provider level of benefits ends after the (a) 90th day from the effective date of

the provider's termination; (b) ninth month, in case of a Covered Person who at the time of provider termination has been diagnosed with a terminal illness or (c) through delivery of the child, immediate post-partum care and follow-up checkup within the first six weeks of delivery, in the case of an Insured who at the time of the provider's termination is past the 24th week of pregnancy.

If the Company does not agree with the continued treatment, the provider may appeal the Company's decision.

7. **Non-PPO Benefits.** Reimbursement for services by Non- Preferred Providers generally will be less than payment for the same services when provided by a Preferred Provider and could result in substantial additional out-of-pocket expense. The Non-PPO or Out-of-Network Deductible, Coinsurance and Calendar Year Coinsurance Maximum set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Non-Preferred Provider, unless:
 - a. **Plan Provision.** The Schedule of Benefits or this Benefit Certificate provides a different Deductible, Coinsurance or Calendar Year Coinsurance Maximum for the particular service or supply that is the subject of the claim;
 - b. **Emergency Services.** When a Covered Person receives covered Emergency Care services (see Subsection 9.36) from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Covered Person can be safely transferred to a Preferred Provider, the Covered Person will be required to be transferred to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Covered Person chooses not to transfer, benefits will be payable at the Non-Preferred Provider level of benefits.
 - c. **Services Not Available In-Network.** When a Covered Person requires Covered Services which are not available through a Preferred Provider, benefits for Covered Services received from Non-Preferred Providers will be paid as if the Covered Services were received from Preferred Providers.
 - d. **Child Subject to Medical Support Order.** Covered Services received from Non-Preferred Providers will be paid at the Preferred Provider level of benefits for an Insured Child who is the subject of a medical support order and lives outside the PPO Service Area.
8. **Payment to Preferred Providers.** When services are received from Preferred Providers, benefit payments will be made directly to the Preferred Providers. This will apply regardless of any other provision in the Policy to the contrary.
9. **No Balance Billing from Preferred Providers.** Preferred Providers are Physicians or Hospitals who are paid directly by the Company and have agreed to accept the Company's payment for covered services as payment in full except for your Deductible, Coinsurance, Copayment and any specific benefit limitation, e.g. Home Health visits are limited to 60 per year (Subsection 3.17), if applicable. **A Covered Person is responsible for billed charges in excess of the Company's payment when Physicians or Hospitals who are not a Preferred Provider render services. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person. However, if the services provided are for Emergency Care or the Non-Preferred Provider was used because no Preferred Provider was reasonably available within the service area, the Company will credit to the Deductible and to the Annual Limit on Cost Sharing any out-of-pocket amounts you paid to the Non-Preferred Provider for charges for covered services beyond the Allowable Charge.**
10. **Certain Services may not be In-Network Benefits.** Do not assume that a PPO Provider's agreement includes all covered benefits. In particular all services provided at a PPO Hospital may not be provided by a PPO Provider; e.g. anesthesia, radiology or Laboratory tests. Some PPO Providers contract with the Company to provide only certain covered benefits, but not all covered benefits. Some Providers choose to be a PPO Provider for only some of our products. Refer to the Provider directory, ask your Provider or contact Customer Service for assistance. **Your Provider may not be In-Network for all services.**
11. **Relation of the Company to Providers.** The decision about whether to use a Preferred Provider is the sole responsibility of a Covered Person. Preferred Providers are not employees

or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

12. **Retaliation.** The Company will not take any retaliatory action against (a) a Covered Person because the Covered Person, or other person on behalf of the Covered Person, appeals a decision made by the Company or files a complaint against the Company or a Preferred Provider; (b) a Preferred Provider who, on behalf of a Covered Person, reasonably files a complaint against the Company or appeals a decision of the Company.
13. **Scope of Provider Payment - Global Payment.** The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Benefit Certificate with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Benefit Certificate, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Benefit Certificate are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Benefit Certificate for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Benefit Certificate is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a Laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Benefit Certificate shall nevertheless be limited to one Allowance or Allowable Charge per CPT or HCPCS code; in

such circumstances, your benefits under this Benefit Certificate will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Benefit Certificate are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Benefit Certificate will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

5.2. **Covered Person's Financial Obligations for Allowable Charges under the Plan**

1. **Deductible.** For those covered Health Interventions, which are specified in the Schedule of Benefits as being subject to a Deductible, each calendar year, before the Plan makes a benefit payment, a Covered Person must pay the cost of Covered Services equal to the Deductible specified in the Schedule of Benefits. If the Plan provides family coverage, once two family members have met their individual Deductible, no further Deductible will be required for the balance of the year, regardless of what member of the family incurs a claim. Deductible payments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.
2. **Coinsurance.** Once the Deductible is satisfied, a Covered Person is responsible for Coinsurance, which is a percentage of Allowable Charges paid, for claims incurred until the Covered Person's payment equals the Annual Limitation on Cost Sharing specified in the Schedule of Benefits. After the Annual Limitation on Cost Sharing is satisfied, subject to the provisions of this Subsections 5.2 of this Benefit Certificate, the Covered Person will have no further responsibility with respect to Allowable Charges incurred during the balance of the calendar year for services received from a **Preferred Provider**.
3. **Copayments.** In order to receive certain Health Interventions from an In-Network Provider, a Covered Person may have to pay a Copayment, which is expressed as either a dollar amount or a percentage of the Allowance or Allowable Charge in the Schedule of Benefits. Copayments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.
4. **Allowable Charges Not Applicable to Annual Limitation on Cost Sharing.** No Allowable Charges paid for services or supplies from Non-Preferred Providers shall accumulate to or be impacted by the satisfaction of the Deductible or the Annual Limitation on Cost Sharing, unless the Company determines that the Non-Preferred

Provider should be treated as a Preferred Provider in accordance with one of the provisions listed in Subsection 5.1.7.

5.3 Other Plans and Benefit Programs

1. **Coordination of Benefits.** Coordination of Benefits (COB) applies when a Covered Person has coverage under more than one Health Benefit Plan. The Company may annually request that a Covered Person verify the existence of other coverage.

a. **Definitions.** For purposes of this Subsection 5.3 only, the following words and phrases shall have the following meanings:

i. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

ii. "Health Benefit Plan" means any of the following, which provide coverage for medical care or treatment:

(1) Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.

(2) Group coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including health maintenance organization or other form of group coverage; hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts; and medical benefits under group or individual automobile contracts.

(3) An individually underwritten accident and health insurance policy which reduces benefits because of the existence of other insurance.

(4) Coverage under any automobile insurance policy, including but not limited to medical payment, personal injury protection or no-fault benefits.

The term "Health Benefit Plan" shall be construed separately with respect to:

(1) Each Policy, contract or other arrangement for benefits or services.

(2) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.

b. The Company shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering a Covered Person.

The rules establishing the order of benefit determination between this Benefit Certificate and any other Health Benefit Plan covering the Covered Person on whose behalf a claim is made are as follows:

i. The benefits of a Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Benefit Certificate.

ii. If according to the rules set forth in Subsection c. of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan.

iii. Under no circumstances shall benefits payable and paid under this Plan together with any other Health Benefit Plans exceed the total charge for services a Covered Person received.

c. **Order of Benefit Determination:** The order of benefit determination as to a Covered Person's claim shall be as follows:

- i. **Non-Dependent or Dependent.** The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent. (By way of example only, if one Plan [Plan A] covers a person as an employee and the other plan covers the person as a dependent of an employee [Plan B], then Plan A is deemed “primary” and Plan A’s benefits will be applied and paid before any consideration of Plan B.)
- ii. **Child Covered Under More Than One Plan.** When the parents of a dependent child are married, the benefits of a plan which covers the person on whose expenses a claim is based as a dependent child of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent child of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If the other plan does not have the provisions of this paragraph regarding coverage of dependent children of married parents, or if both parents have the same birthday, the plan that has covered either of the parents longer is primary.

The following rules apply to determine the order of benefit determination for a dependent child of parents who are separated or divorced:

- (1) When the parents are separated or divorced and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.
 - (2) When the parents are separated or divorced and the parent with custody of the child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - (3) When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
- iii. **Active or Inactive Employee.** When paragraphs (i) or (ii) above do not apply so as to establish an order of benefits determination, the plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule set out in paragraph (i) above.
 - iv. **Continuation coverage.** When paragraphs (i), (ii) or (iii) above do not apply so as to establish an order of benefits determination, if a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is

primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- v. **Longer or Shorter Length of Coverage.** When paragraphs (i), (ii), (iii) or (iv) above do not apply so as to establish an order of benefits determination, the plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of health benefit plan, Subsection 5.3.1.a.(ii). In addition, this plan will not pay more than it would have paid had it been primary.

2. **Medicare, Military or Government Benefits.** If a Covered Person is a Medicare beneficiary, benefits under the Plan will be determined in accordance with the Medicare Secondary Payer rules. Services and benefits for treatment of military service-connected disabilities to which a Covered Person is legally entitled from a military or government benefit plan shall in all cases be provided before the benefits of this Benefit Certificate.

3. **Workers' Compensation.** There are no benefits under this Benefit Certificate for treatment of any injury which will sustain a claim for damages from Workers' Compensation. This regardless of whether or not the Covered Person filed a claim for workers' compensation benefits.

The Company will presume that if the Covered Person makes a claim for worker's compensation benefits, the injury for which the Covered Person makes any such claim is an injury which will sustain a claim for damages under the Workers' Compensation Law. Therefore, the Company will not be liable for payment of any benefits as to such a claim, unless the full Workers' Compensation Commission finds that the Covered Person's injury was not a compensable injury; and, the finding is not overturned on appeal. The foregoing presumption of non-coverage under this Benefit Certificate also applies to any case in which the Covered Person's workers' compensation benefits claim is settled by joint petition or otherwise. In this case, no benefits will be paid under this Benefit Certificate with respect to such a claim, regardless of the settlement amount.

Nor will the Company pay benefits for injury or illness for which the Covered Person receives any benefits under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to the Covered Person's benefits claim under such laws.

In the event that the Company pays any claim by the Covered Person for benefits under this Benefit Certificate, and subsequently learns that the Covered Person has filed a claim for workers' compensation benefits as to such claim, or that the Covered Person has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Covered Person agrees to reimburse the Company to the full extent of its payments on such claim.

4. **Acts of Third Parties (Subrogation/Reimbursement).** If a Covered Person is injured by a third party, the Company is subrogated to all rights the Covered Person may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided as provided by Subsection a or b.

- a. This subsection applies when a Covered Person is not represented by an attorney in obtaining a recovery. The Company's share under this Subsection 5.3.4 of the Covered Person's recovery is an amount equal to the lesser of:
 - i. one-half of the Covered Person's gross recovery; or
 - ii. the total cost of benefits paid, provided or assumed by the Company as a direct result of the tortious conduct of the third party.

- b. This subsection applies when a Covered Person is represented by an attorney in recovery. The Company's share under this Subsection this Subsection 5.3.4 of the Covered Person's recovery is an amount equal to the lesser of:

- i. one-half of the Covered Person's gross recovery less attorney's fees and procurement costs provided by Texas Civil Practice and Remedies Code §140.007; or
- ii. the total cost of benefits paid, provided or assumed by the Company as a direct result of the tortuous conduct of the third party less attorney's fees and procurement costs provided by Texas Civil Practice and Remedies Code §140.007.

The Covered Person must cooperate fully with the Company in its efforts to collect from the third party, See Subsection 5.3.4. The Company may assert its subrogation rights independently of the Covered Person. In addition to the above-referenced subrogation rights, the Company also has reimbursement rights should the Covered Person, or the legal representative, estate or heirs of the Covered Person recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Covered Person shall promptly reimburse the Plan any monetary recovery made by the Covered Person and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source.

- 5. **Covered Person's Cooperation.** Each Covered Person shall complete and submit to the Company such consents, releases, assignments and other documents as may be requested by the Company in order to obtain or assure reimbursement from other health benefit plan(s), from Medicare, from Workers' Compensation, or through subrogation. Any Covered Person who fails to so cooperate will be liable for and agrees to pay to the Company the amount of funds the Company had to expend as a result of such failure to cooperate, and the Company shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments or credits due under this Policy in order to collect the Covered Person's liability resulting from his or her failure to cooperate.
- 6. **The Company's Right to Overpayments.** Whenever payments have been made by the Company in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Benefit Certificate, the Company shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Company shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance Company or companies; or any other organization or organizations to which such payments were made.

6.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards of this document, you still must be eligible for benefits under your Plan and your coverage must be in effect at the time you receive such Intervention in order to receive benefits. This Section sets out the standards for eligibility under the Plan, Subsection 6.1; the policies for determining a Covered Person's effective date, Subsection 6.2; policies governing termination of coverage, Subsection 6.3; and the options a person who has lost eligibility may have under state and federal law to continue coverage under the Plan, Subsection 6.4.

6.1 **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Employees and Dependents by the Company. In order to be covered, you must meet either the requirements for an Employee or a Dependent.

- 1. **Employee Coverage.**
 - a. To be eligible, an Employee:
 - i. must work on a full-time basis;
 - ii. usually work at least thirty (30) hours a week;
 - iii. included as an employee under the Health Benefit Plan of the Employer.
 - b. An individual is not an Eligible Employee if:
 - i. he or she works on a part-time, temporary, seasonal or substitute basis; or
 - ii. he or she is covered under:
 - (1) another health benefit plan;
 - (2) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the

Employee Retiree Income Security Act of 1974 (29 U.S.C. §1001 *et seq.*) ("ERISA");

- (3) the Medicaid program if he or she elects not to be covered by the Plan;
- (4) another federal program, including CHAMPUS program or Medicare program; or
- (5) a benefit plan established in another country if he or she elects not to be covered by the Plan.

c. Employees who are married have the option to elect Employee Coverage for each spouse or Employee and Dependent Coverage.

2. **Dependent Coverage.** Eligible Dependents are the Employee's:

- a. Spouse;
- b. Child less than 26 years of age;
- c. Grandchild who is unmarried and less than 25 years of age who is dependent on the Employee for federal income tax purposes at the time of application;
- d. Child who is medically certified as disabled and dependent on the Employee, provided 1.) such Child is or was under the limiting age of dependency stated in Subsections b. above at the time of application for coverage in the Plan or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan;
- e. Child for whom the Employee is required to insure under a medical support order enforceable by a court;
- f. Any other Child included as an Eligible Dependent under the Plan.

Note: Domestic partners are not eligible for coverage as Dependents under this Benefit Certificate.

Note: The marital status of an Employee and the other parent shall not be used in determining the Dependent of the Employee.

3. **Additional Eligibility Requirements for Dependent Coverage.** In order for an Employee's Dependent to be eligible for coverage:

- a. the Employee must be eligible for and have coverage; and
- b. the Dependent must not be in active military service.
- c. If the parents of a Child both have Employee Coverage, Dependent Coverage of the Child is only available through one of the parents.

4. **Proof of Mental Retardation or Physical Disability.** In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or disability must be furnished to the Company prior to the Child's attainment of the applicable limiting age referenced in section 6.1.2.b. above. Such proof must at least demonstrate that the Child is incapable of self-sustaining employment because of mental retardation or physical disability and that he or she is chiefly dependent on the Employee for support and maintenance. Subsequent evaluation for continued retardation or physical disability and dependency may be required by the Company, but not more frequently than once per year. An Employee who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age, and the Child has been continuously covered under a health benefit plan as a Dependent of the Employee since before attaining the limiting age.

5. **Military Duty.** If a Covered Person is called to active duty in the armed services of the United States of America, the Covered Person's (and any covered dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA). A former Covered Person returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The Company may require a copy of the returning member's orders terminating the active duty or other proof of the active duty or termination date thereof.

6.2 **Effective Date of Coverage.** The following provisions outline the Company's policies relative to effective dates of coverage for you and/or your dependents.

1. **Application and Effective Date.** In order for an Employee's coverage to take effect, the Employee must submit a written application for coverage for the Employee and any Dependents. The effective date(s) of coverage shall be determined in accordance with this Subsection 6.2 and indicated by the Company on the ID card, Schedule of Benefits or letter issued to Covered Persons by the Company.
2. **Employees and Dependents on Contract Effective Date.** Coverage under this Benefit Certificate shall become effective on the Group Contract effective date for all Employees and Dependents for whom an enrollment application is completed and premium is paid during the enrollment period prior to the Group Contract effective date.
Coverage will be extended to an eligible Employee or Dependent who is an inpatient in a Hospital on the effective date.
3. **Initial Enrollment for New Employee Effective Date.** If the Company receives a new Employee's enrollment application within thirty one (31) days of the completion of the Waiting Period established by the Employer, the Employee's coverage will become effective 12:01 a.m. on the first day of the Policy Month following the date the Employee is first eligible for coverage. However, if the date the Employee is first eligible for coverage falls on the first day of the Policy Month, the Employee's coverage will become effective at 12:01 a.m. on that day.
4. **Coverage in the Case of Late Enrollment.** Late Enrollee means any Eligible Employee or Dependent who requests enrollment in the Employer's Health Benefit Plan after the expiration of the Initial Enrollment Period or after the expiration of the annual Open Enrollment Period.
5. **Initial Enrollment Period** is the defined time frame for enrollment outlined in the Effective Dates provision, Subsection 6.2.3.
6. **Open Enrollment Period.** The Open Enrollment Period is the time period provided annually in which an Employee and Dependents may enroll for coverage. It must be a 31 day period consisting of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period shall last through March 2. If the Employee or Dependent is a Late Enrollee, the Employee or Dependent cannot subsequently obtain coverage, except during a Special Enrollment Period or during an Open Enrollment Period. The Open Enrollment Period occurs annually during the entire month specified by the plan. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy.
7. **Effective Date for Existing Dependents.** If the Employee has eligible Dependents on the date the Employee's coverage begins, the Employee's Dependents' coverage will begin on the Employee's effective date if:
 - a. The Employee submits a written application for Dependents' coverage within 31 days of the Employee's effective date; and
 - b. The appropriate premium is timely paid.
8. **Effective Date for Newly Acquired Dependents.** In no event will an Employee's Dependent's coverage become effective prior to the Employee's effective date. If an Employee acquires a new eligible Dependent after the date the Employee's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:
 - a. **Spouse.** When an Employee marries and wishes to have the Employee's Spouse covered, the Employee shall submit an application or change form within 31 days of the date of marriage. The effective date will be the first of the month following the date of marriage. If an Employee submits the application or change form after the 31-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4 above.
 - b. **Newborn Children.** Coverage will be automatic for the first 31 days following the birth of the Employee's newborn Child and will terminate on the 32nd day. To continue coverage beyond 31 days, the Employee must notify the Company within 31 days of birth and pay the required premium within the 31 day period or a period consistent with the Company's next billing cycle. If the Employee notifies the Company after that 31 day period, his newborn Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4 above.

If the Employee decides not to continue coverage for his Dependent Child beyond the 31 day period, premium will be charged for the 31 days coverage was in force.

- c. **Court Ordered Coverage for a Child.** If a court has ordered an Employee to provide coverage for a Child, the Company shall enroll the Employee, if not already covered, and the Child. The Company will accept an enrollment application from either the Employee, the custodial parent of the Child, the Child or a child support agency having a duty to collect or enforce support of the child. Coverage will be automatic for the first 31 days following the date the Employer receives notification of the court order. To continue coverage beyond 31 days, the Company must be notified and the required premium must be paid within the 31 day period.
- d. **Newly Adopted Children.** Coverage will be automatic for a newly adopted Child for the first 31 days from the date that a Covered Person is a party in a suit for adoption or 31 days from the date the adoption is final. To continue coverage beyond 31 days, the Company must be notified that a Covered Person is a party in a suit for adoption or the adoption is final and the required premium is paid within either of the 31 day periods or a period consistent with the Company's next billing cycle. If notification is received after either of the 31 day periods, coverage for the newly adopted Child will begin effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4 above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.
- e. **Other Dependents.** Written application for enrollment received by the Company within 31 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such dependent on the first day of the month following the date that application for coverage is received by the Company. Such Dependent will not be a Late Enrollee. If the Employee submits the application or change form after the 31-day period, coverage for the Dependent will become effective on the first of the month following the Company's receipt of the application or change form and the Dependent will be a Late Enrollee.

9. **Special Enrollment Period** is the 31-day period during which time an Employee or Dependent may enroll in the Plan, after his or her initial Eligibility Date or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in the following instances:

- a. A Dependent of the Employees loses Minimum Essential Coverage under another health plan for reasons other than failure to pay premiums or justified rescission.
- b. The Employee gains a Dependent through marriage, birth, adoption or placement for adoption.

10. **Medicaid or State Child Health Insurance Program ("CHIP") Special Enrollment Period** is a 60-day period during which time an Employee or Employee's dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. Medicaid or CHIP Special Enrollment Periods occur **ONLY** in two instances:

- a. **After the Termination of Medicaid or CHIP Coverage.** A Medicaid or CHIP Special Enrollment Period begins on the day an employee's or dependent's coverage under Medicaid or CHIP terminates as a result of Loss of Eligibility.
- b. **After Eligibility for Employment Assistance under Medicaid or CHIP.** A Medicaid or CHIP Special Enrollment Period occurs for an employee or employee's dependent who becomes eligible for assistance, with respect to coverage under group health plans or health insurance plans under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation Medicaid or CHIP).

6.3 **Termination of Coverage.** The following provisions outline the Company's policies relative to termination of coverage for you and/or your dependents.

1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Covered Person shall terminate if any of the following events occur:

- a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:
 - i. This Plan terminates.

- ii. The Employer to which the Group Policy is issued, terminates or ceases to sponsor the Plan.
 - b. Coverage shall terminate at 12:00 midnight Central Time on the last day of the Policy Month in which the event occurs when:
 - i. The Covered Person ceases to be eligible as an Employee or Dependent for any reason.
 - ii. The Covered Person is a Dependent Spouse who becomes legally separated or divorced from the Employee.
 - c. Any Covered Person's coverage shall terminate at 12:00 midnight Central Standard Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.
- 2. **Termination of a Covered Person's Coverage for Cause.**
 - a. **Bases for Termination.** The Company may terminate coverage under this Benefit Certificate, including termination by rescission of all coverage retroactive to the Covered Person's original effective date, upon thirty (30) days' written notice for:
 - i. fraudulent or intentional misrepresentation of material fact, in obtaining coverage; or
 - ii. fraudulent or intentional misrepresentation of material fact, in the filing of a claim for services, supplies, or in the use of services or facilities.
 - b. **Fraud or Intentional Misrepresentation of Material Fact.** For purposes of this termination for cause provision, fraud or an intentional misrepresentation of material fact occurs if (i) information is withheld or if intentionally incorrect information is provided that is material to the risk assumed by the Company, or (ii) the Company would not have issued this Benefit Certificate, would have charged a higher premium, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Benefit Certificate.
 - c. **Termination Effective Date.** Rescission of coverage shall become effective on the Covered Person's original effective date. If the Company elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to the Company; or (ii) the date stated in the termination notice letter to Covered Person.
 - d. **Appeal Procedure.** A Covered Person may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of USAble Mutual Insurance Company, [Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203.] In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by Covered Person to Company; or (ii) the termination effective date stated in the termination notice letter to Covered Person.
- 3. **Premium Refunds.** If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and the Company shall have no further liability under this Group Policy.

If the Employer terminates coverage of a Covered Person, the Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

4. **Termination of the Group Contract, Impact on Covered Persons.** The coverage of all Covered Persons shall terminate if the Group Contract is terminated.

6.4 **Continuation Privileges**

1. **Continuation of Hospital Benefits When Group Contract is Replaced.** If a Covered Person is hospitalized on the date the Group terminates coverage with the Company and replaces the coverage with another company, coverage for the Covered Person will continue until the date the Covered Person is discharged or until benefits under the Plan are exhausted, whichever occurs first.

2. **Continuation Rights under State Law**

- a. If an Employee's employment terminates the Employee shall have the right under state law to elect continuation of coverage under the Plan as outlined below. In order to be eligible for this option,
- i. the Employee's coverage under the group policy must be terminated for any reason other than involuntary termination for cause;
 - ii. the Employee must have been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination; and
 - iii. the Employee must provide to the Policyholder a written request for continuation of group coverage not later than the 60th day after the latter of
 - (a) the date the group coverage would otherwise terminate; or
 - (b) the date the Employee is given notice by the Policyholder of the right to continuation of group coverage.
 - iv. "Termination for cause" does not include termination for any health-related cause.
- b. Continuation shall terminate on the earliest of:
- i. for an Employee not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine months after the date the Employee elects to continue the group coverage; or
 - ii. for an Employee eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;
 - iii. the date the Employee fails to make any premium payments or the Policyholder fails to pay the premium to the Company;
 - iv. the date the Employee is or could be covered by Medicare;
 - v. the date on which the Employee is covered for similar benefits under another group or individual Policy;
 - vi. the date the Employee is eligible for similar benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;
 - vi. the date on which similar benefits are provided for or available to the Employee under any state or federal law; or
 - vii. the date on which the Group Policy terminates.
- c. **Additional Continuation Privileges for Certain Dependents**
- i. If coverage terminates as the result of an Employee's death, retirement or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Policy for at least one (1) year, unless the Dependent is an infant under one year of age. Continuation does not require evidence of insurability.
 - ii. Continuation is not available when coverage terminates due to any of the following circumstances:
 - (1) the Policy is canceled, or
 - (2) the Dependent fails to make timely premium payments.
 - iii. Continuation ends at the earliest of the date:
 - (1) Three (3) years after the Employee's death, retirement or divorce;

- (2) the Dependent fails to make timely premium payments;
- (3) the Dependent becomes eligible for coverage under another group plan providing similar benefits; or
- (4) the Policy is canceled.

iv. Notification Requirements

- (1) The Dependent must notify the Policyholder within fifteen (15) days of the Employee's death, retirement, or divorce.
 - (2) The Policyholder will provide written notice to the Dependent of the right to continue coverage and will send the election form, and instructions for premium payment within five (5) working days.
- (3) Within sixty (60) days of the Employee's death, retirement, or divorce, the Dependent must give written notice to the Policyholder of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the sixty (60) day period provided premium is paid.

3. **Continuation Rights under Federal Law.** If Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Group, the coverage of an Employee or Dependent whose coverage ends due to a Qualifying Event may be continued while the Group Contract remains in force subject to the terms of this Section and all terms and provisions of this Benefit Certificate not inconsistent with this Section.

This provision shall not be interpreted to grant to any Covered Person any continuation rights under this Benefit Certificate in excess of those required by COBRA. If the Group fails to comply with the provisions of the Group Policy and this Benefit Certificate concerning COBRA or the notice requirements or other standards under COBRA, the Company shall not assume the Group's obligation to provide COBRA continued coverage under the Plan.

- a. **Qualifying Events.** The following is a list of events which could result in termination of a Covered Person's coverage under this Benefit Certificate. If such should occur, for purposes of this Section, the event shall be called a Qualifying Event.

- i. An Employee's death.
- ii. Termination of an Employee's employment (other than by reason of the Employee's gross misconduct), or of an Employee's eligibility due to reduction in the Employee's hours of employment.
- iii. An Employee's and Spouse's divorce or legal separation.
- iv. An Employee becoming entitled to Medicare.
- v. A Dependent Child ceasing to be a Dependent Child as defined in this Benefit Certificate.

- b. **Requirements for COBRA Continuation.** Continuation under this Subsection is subject to a Covered Person requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:

- i. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Covered Person elects to continue coverage; and
- ii. The Group, as Plan Administrator, must have provided the Covered Person an initial notice of COBRA rights at the time coverage commenced under the Plan (this Benefit Certificate); and
- iii. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and
- iv. The Covered Person must notify the Plan Administrator within 60 days of the happening of Qualifying Event (iii) or (v) in Section 6.4.3.a, above; and

- v. The Covered Person must elect to continue coverage under the Plan within 60 days of the later of:
 - (1) the date the notification of election rights is sent, or
 - (2) the date coverage under the Plan terminates.

If an election is not made by the Covered Person within this 60-day period, the option to elect COBRA shall end.

If an Employee with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Employee asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Covered Person shall include coverage for all Dependents of the Employee who were covered.

- c. **Coverage Continued.** The coverage continued for a Covered Person in accordance with this Section shall be the same as otherwise provided under this Benefit Certificate for other Covered Persons in the same benefit class in which such Covered Person would have been covered had his or her coverage not terminated.
- d. **Effective date.** The effective date for COBRA continuation is the date coverage under the Plan terminates due to a qualifying event.
- e. **Termination.** Once in effect, COBRA continuation coverage for a Covered Person under this Section shall terminate on the earliest to occur of the following applicable dates:
 - i. The date the Group Contract terminates;
 - ii. At the end of the last period for which premium contributions for such coverage have been made, if the Covered Person or other responsible person does not make, when due, the required premium contribution to the Group;
 - iii. The date ending the maximum period. In the Case of Qualifying Event 6.4.3.a.(ii) above (relating to termination of employment or reduction in hours), the date ending the maximum period shall be the date 18 months after the date of that Qualifying Event; unless the Social Security Administration determines that the Covered Person is disabled at the time of or within 60 days after the Qualifying Event, and the Covered Person provides the notice of Social Security disability determination to the Plan Administrator within 60 days of the date of the Social Security determination and before the end of the initial 18-month period of continuation, in which case this date shall be 29 months after the Qualifying Event. In all other cases, such date shall be the date 36 months after the date of the applicable Qualifying Event;
 - iv. The date the Covered Person becomes covered under any other group health plan that provides coverage for Preexisting Conditions;
 - v. The date the Covered Person becomes entitled to Medicare;
 - vi. The date the Covered Person's coverage is terminated for cause. See Section 6.3.2 above.

7.0 CLAIM PROCESSING AND APPEALS

In reviewing a claim for benefits, the Company will apply the terms, conditions, exclusions and limitations of the Plan set out in this Benefit Certificate, including but not limited to the Primary Coverage Criteria, Section 2.0; the specific limitations of the Plan, Section 3.0; the specific plan exclusions, Section 4.0; the cost sharing and Provider network procedures of the Plan, Section 5.0; and the eligibility standards of the Plan, Section 6.0.

This Section 7 sets out the procedures you must follow in submitting a request for coverage, called a "claim for benefits" or a "claim," with your Plan, Subsection 7.1. The section also describes your rights to appeal if a claim for benefits is denied either in whole or in part, Subsections 7.3 and 7.4. Finally, this section sets out how you may have an Authorized Representative to represent you in submitting claims or appeals, Subsection 7.5.

7.1 Claim Processing.

1. **Claim for Benefits.** "Claim for benefits" means (1) a request for payment for a service, supply, prescription drug, equipment or treatment covered by the Plan or (2) a request for Preauthorization for a service, supply, prescription drug, test, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, prescription drug, equipment or treatment on approval in advance by the Company. Within 20 days after a Covered Person receives Covered Services, or as soon as reasonably possible, the Covered Person, or someone on his behalf must notify the Company in writing of his claim.
2. **Who May Submit a Claim.** A Covered Person, a Provider with an assignment of the claim or the Covered Person's Authorized Representative may submit a claim. See Subsection 7.5 below concerning the Authorized Representative.
3. **Classifications of Claims.** There are four general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by the Company.

- a. **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Covered Person obtains a medical service, prescription drug, supply, test, equipment or other treatment and then, in accordance with the terms of the Plan, the Covered Person or the Covered Person's Authorized Representative submits a claim for benefits to the Company. Examples of post-service claims are claims involving physician office visits, maternity care, outpatient services, and most prescription drugs obtained through a managed pharmacy benefit.

You must submit written proof of any service, supply, prescription drug, test, equipment or other treatment within 180 days after such service, supply, prescription drug, test, equipment or treatment was received. In the case of a claim for inpatient services for multiple consecutive days, the written proof must be submitted no later than 180 days following your date of discharge for that single admission. Failure to submit written proof within this 180 day time will not invalidate or reduce any claim if it is shown that (1) it was not reasonably possible to give the notice within this time; and (2) notice was given as soon as reasonably possible.

Post-Service Claims may be submitted electronically in accordance with the Company's electronic claim filing procedures, or such claims may be mailed to USABLE Mutual Insurance Company Claims Division, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203. Claim forms are available on the Company's web site at WWW.USABLEMUTUAL.COM or the Company will mail you a claim form if you request it by telephoning Customer Service at (800) 519-2583 or by mailing your request to the Claims Division.

If the Company is able to process your post-service claim without requesting additional information, it will notify you of its claim determination within 30 days of the Company's receipt of the claim. The Company will forward any payment resulting from the claim determination within 45 days (30 days if the claim is submitted electronically) of the Company's receipt of the claim.

If the Company requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, as specified in Subsection 7.1.4. below, the Company will suspend the claim and request the needed information. If you or your treating Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify you of its claim determination within 15 days after the Company receives such information. The Company will forward any payment resulting from the claim determination within 30 days of the Company's receipt of the required information. If the Company does not receive the required information within the 90-day period, 15 days later, the suspended claim becomes a denied claim, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

- b. **Pre-Service Claims.** The terms of the Plan condition receipt of certain benefits on the Company giving approval in advance of the Covered Person obtaining a requested medical service, drug, supply, test or equipment that such medical service, drug, supply, test or equipment meets Primary Coverage Criteria. Examples of some Plan

benefits requiring pre-service claims are claims for Hospital Services in Connection with Dental Treatment, Subsection 3.2.3; Advanced Diagnostic Imaging Services, Subsection 3.5; Durable Medical Equipment that costs more than \$5,000, Subsection 3.11; Prosthetic Devices that cost more than \$20,000, Subsection 3.13; certain Prescription Medications, Subsection 3.22; most organ transplants, Subsection 3.23. **Please note that if the Company gives Preauthorization for a Health Intervention, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.**

Pre-service claims should be submitted to the USABLE Mutual Insurance Company Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203.

If the Company is able to process your pre-service claim without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 3 days from the date it received the pre-service claim.

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, the Company will suspend the claim and request the needed information. If you or your treating Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify you of its claim determination within 3 days after the Company receives such information. If the Company does not receive the required information within the 90-day period, 3 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.2. Claim Appeals to the Plan.

After you have received the Health Intervention that was the subject of an approved pre-service claim, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- c. **Claims Involving Urgent Care.** A claim involving urgent care must be a pre-service claim (See Subsection 7.1.3.b. above) for which a health care professional with knowledge of the claimant's condition certifies that the processing of the claim in the time period for making a non-urgent pre-service claim determination (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to maintain or regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim involving urgent care must be submitted in writing, via mail, facsimile or e-mail, in a format authorized by the Company's claim filing procedures. **A claim involving urgent care must include the medical records pertinent to the urgent condition.**

If the Company is able to process your claim involving urgent care without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 72 hours from the date it received the pre-service claim.

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, the Company will notify your physician within 24 hours of receiving the claim and request the needed information. If you or your treating Provider supplies the Company the required information within 48 hours, the Company will notify you of its claim determination within 48 hours after the Company receives such information. If the Company does not receive the required information within the

48-hour period, the claim will be denied, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

If the urgent care claim is a request to extend previously approved benefit for ongoing treatment, the Company shall make a determination within 24 hours after receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the previously approved benefit.

Please note that if the Company gives Preauthorization for a Health Intervention involving urgent care, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate.

After you have received the Health Intervention that was the subject of a claim involving urgent care, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- d. **Claims involving Ongoing Care or Concurrent Review.** The Company's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. The Company shall give an explanation of the reduction or termination of a benefit to the Covered Person, as specified in Subsection 7.1.6, with sufficient time prior to the termination or reduction to allow for an appeal under Subsection 7.3.7.d. to be completed before the termination or reduction takes place.

4. **Information Reasonably Necessary to Process a Claim.**

- a. In order to be a claim, the submission must comply with the filing and coding policies and procedures established by the Company. You may request a copy of the claim coding policies and procedures from the Company or from your Provider. If the submission fails to comply with the claim filing or coding policies or procedures, the Company shall return the submission to the person that submitted it. If the claim involved is a pre-service claim, the submission shall be returned as soon as possible, but no later than 5 days (24 hours for a claim involving urgent care), and the Company shall indicate on the returned submission the proper procedures to be followed.
- b. In addition to the claim completed in accordance with the Company's claim filing procedures, depending upon the service, supply, prescription drug, equipment or treatment that is the subject of the claim, the Company may require one or more of the following items of information to enable the Company to determine whether or to what extent the claimed benefit is covered by the Plan:
- i. Information in order to determine if a limitation or exclusion of the Plan is applicable to the claim, or
 - ii. Medical information in order to determine the price for a medical procedure, or
 - iii. Information in order to determine if the Covered Person who received the claimed services is eligible under the terms of the Plan, or
 - iv. Information in order to determine if the claim is covered by another health benefit plan, workers' compensation, a government supported program, or a liable third party, or
 - v. Information in order to determine the obligation of each health benefit plan or government program under coordination of benefits rules, or
 - vi. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim.

- vii. payment from the policyholder of premiums that were delinquent at the time the claimed services were rendered.
5. **Covered Person's Responsibility with Respect to Claim Information.** Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider of medical services or supplies to furnish to the Company, its agents, or any of its affiliates, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you agree to authorize the release of such records to any third party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Company or failure to cooperate fully to obtain information requested by the Company from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.
6. **Explanation of Benefit Determination.** Upon making a determination of a claim, the Company will deliver to you the following information:
 - a. The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, and a way the Covered Person may learn the diagnosis and treatment codes and their descriptions)
 - b. Reference to the specific plan provision(s) on which the determination is based;
 - c. A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;
 - d. A description of the Plan's appeal process, see Subsection 7.3 below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 7.3.7.c. below;
 - e. If the determination was based in whole or in part on a Company Coverage Policy, an explanation of how to obtain a copy of the Coverage Policy at no cost. See Subsection 2.4.1.f. above.
7. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone - toll free number listed on your ID card, or write USABLE Mutual Insurance Company, Customer Service, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 7.3 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.
8. **Benefit Inquiries.** From time to time you or your Provider may want an indication whether a service, supply, prescription drug, equipment or treatment is an eligible benefit of the Plan. You may make a benefit inquiry to USABLE Mutual Insurance Company Customer Service Division, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203, or by calling the toll free telephone number listed on your ID Card.
 - a. A benefit inquiry is not a claim. You should understand that a benefit inquiry is different from a pre-service claim. In the case of a benefit inquiry, the Plan does not specify that receipt of the benefit in question is conditioned upon Preauthorization of the Company (see Subsection 7.1.3.b Pre-Service Claims, above).
 - b. **The Company's response to a benefit inquiry is not a guarantee of payment. The Company's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** A benefit inquiry is not a claim. The Company's response to a benefit inquiry is not a claim determination. The Company's response is based upon the information available to the Company at the time of the inquiry and such information may not be current or accurate. The Company reserves the right to make a final determination of the post-service claim resulting from a Health Intervention that may have been the subject of a

benefit inquiry after the intervention has been completed and all relevant facts are known.

- c. A benefit inquiry is not subject to appeal.

9. **Payment of Claims.**

- a. **Time of Payment.** The Company will forward any payment resulting from the claim determination within 45 days (30 days if the claim is submitted electronically) of the Company's receipt of the claim.

- b. **Payment to the Covered Person.**

Benefits will be paid to the Covered Person. Any benefits that are unpaid at the death of the Covered Person will be paid either to the Covered Person's Beneficiary or to the Covered Person's estate, if no Beneficiary is named.

If benefits are payable to the Covered Person's Estate or to the Covered Person or to a Beneficiary of the Covered Person who cannot execute a valid release, the Company may pay benefits up to \$1,000 to someone related to the Covered Person or a Beneficiary by blood or marriage whom the Company deems to be equitably entitled to such benefits. The Company will be discharged to the extent of any such payments made by the Company in good faith.

- c. **Payment to a Conservator.**

Benefits paid on behalf of a covered Dependent Child may be paid to a person who is not the Employee, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the Child.

To be entitled to receive benefits a managing conservator of a Child must submit to the Company with the claim form written notice that such person is the managing conservator of the Child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Employee where the Employee has paid any portion of a medical bill that would be covered under the terms of the Policy.

- d. **Payment to Texas Department of Human Services.**

When services are paid for or rendered by the Texas Department of Human Services on behalf of an Employee or Dependent, payment for the services will be made directly to the Texas Department of Human Services. In the case of a Dependent Child, when services are paid to or rendered by the Texas Department of Human Services, payment for such services will be made directly to the Texas Department of Human Services if:

- (1) the parent who is an Employee is:
 - (a) a possessory conservator of the Child under an order issued by a court in Texas; or
 - (b) is not entitled to possession of or access to the Child and is required by court or court approved agreement to pay child support;
- (2) the Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and
- (3) The Company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the Company that benefits must be paid directly to the Texas Department of Human Services.

- 10. **Covered Person's Responsibility with Respect to Erroneous Claim Payments.** Despite our best efforts, we may make a claim payment which is not for a benefit provided under the Plan, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. If the Company does not receive the full amount of the refund due, the Company will have the right to offset future payments made to you or your Provider under this Policy/ Benefit Certificate or under any other Policy/Benefit Certificate you have with the Company now or in the future.

11. **Physical Examinations and Autopsy**

The Company has the right to require a medical examination, at reasonable intervals, or autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Covered Person will not have to pay for it.

7.2 **Complaints**

1. **Definition.** A complaint is an expression of dissatisfaction about the Company.
2. **Oral Complaints.** A Covered Person having a complaint regarding any aspect of the Company may contact a Customer Service Representative at the toll free telephone number listed on your ID card who will assist in resolving the matter informally. If the Covered Person is not satisfied with the resolution, a written complaint may be submitted. A Covered Person is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints.** The Company will acknowledge receipt of a written complaint within 5 working days. The Company will investigate the complaint and send the Covered Person a response with resolution. If the Company is unable to resolve the written complaint within 30 calendar days due to circumstances beyond its control, the Company will provide notice of the reason for the delay before the 30th calendar day.

7.3 **Claim Appeals to the Plan (Internal Review).**

1. **Legal Actions.** Prior to initiating legal action, you may file an appeal of your claim in accordance with this Subsection 7.3. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.
2. **Who May Request a Review.** A Covered Person or the Covered Person's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 7.5 concerning the Authorized Representative.
3. **Where to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 7.1.6, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Internal Review Request" to the Appeals Coordinator of USABLE Mutual Insurance Company, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203.
4. **Appeals Subject to Direct External Review.**

The Company may waive internal review of any claim determination. If the Company waives internal review, the Company shall defer the claim for external review in accordance with Section 7.3 below.
5. **Documentation.**
 - a. **Written Appeals.** You may submit your appeal orally or in writing. If you make an oral appeal, the Appeals Coordinator will send you a form acknowledging your appeal. Although the Appeals Coordinator will immediately commence consideration of an oral appeal, the Appeals Coordinator requires written confirmation of the appeal.
 - b. **Appellant's Right to Information.** The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:
 - i. were relied upon in making the benefit determination;
 - ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 - iii. demonstrate compliance with the terms of the Plan.; or
 - iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

- c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
 - d. **Appeals Coordinator Right to Information.** You and the treating health care professional are required to provide the Appeals Coordinator, upon request, access to information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Coordinator's request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. See Subsections 7.2.7.c. and d. Your failure to provide access to such information shall not remove the obligation of the Appeals Coordinator to make a determination on the appeal, but the Appeals Coordinator's determination may be affected if such requested information is not provided.
6. **Conduct of Review.**
- a. **Scope of Review.** The Appeals Coordinator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.
 - b. **Qualifications of Appeals Coordinator.** The Appeals Coordinator is an individual with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual.
 - c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to the application of the Primary Coverage Criteria or a Coverage Policy, the Appeals Coordinator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Coordinator shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.
7. **Timing of Appeal Determination.**
- a. **Post-Service Claim.** The Appeals Coordinator shall render a decision on an appeal related to a post-service claim within a reasonable period of time, but notification of the Appeals Coordinator's determination shall be provided to you not later than thirty (30) days after the Appeals Coordinator received the appeal.
 - b. **Pre-Service Claim.** The Appeals Coordinator shall render a decision and provide notification of the decision on an appeal related to a pre-service claim in accordance with the medical exigencies of the case and as soon as possible, but in no case later than fifteen (15) days after the date the Appeals Coordinator received the appeal.
 - c. **Claims Involving Urgent Care.** If you request an expedited review, and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, the Appeals Coordinator shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than one working day after the time the Appeals Coordinator receives the information necessary to process the request for review. See Subsection 7.3.9. below.
 - d. **Concurrent Care Determination.** The Appeals Coordinator shall administer an appeal involving concurrent care in accordance with Subsection 7.3.7.c. as a claim involving urgent care.
8. **Notification of Determination of Appeal to Plan.** The Appeals Coordinator shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

- a. The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);
 - b. reference to the specific plan provision(s) on which the review determination is based;
 - c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;
 - d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;
 - e. a statement describing the voluntary external review procedures offered by the Plan; and
 - f. a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.
9. **Expedited Appeal Procedure.** An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Subsection 7.3.9. Note that submission to the Appeals Coordinator may be done electronically, FAX No. (501) 378-3366, e-mail: APPEALSCOORDINATOR@USABLEMUTUAL.COM. In accordance with Subsection 7.3.5.a., an expedited appeal may be submitted by telephone, (501) 378-2025, followed by a written confirmation. Please refer to Subsection 7.3.5.d. with respect to submission of information concerning a claim involving urgent care or concurrent review to the Appeals Coordinator. In accordance with Subsection 7.3.7.c., the Appeals Coordinator will notify you and your treating health care professional of the determination of your expedited appeal in accordance with the medical exigencies of the case and soon as possible, but in no case later than one working day after the Appeals Coordinator receives the expedited appeal.

7.4 **Independent Medical Review of Claims (External Review)**

1. **Claim Appeals Subject to External Review.**
- a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be sent to external review in accordance with this Section 7.4.
 - b. **Application of Primary Coverage Criteria.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.4 provided:
 - i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or
 - ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination of your claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
 - iii. Your claim meets the requirements for expedited external review. See Subsection 7.4.10.
2. **Where and When to Submit External Review Appeal.** You may request external review by sending a request, using TDI Form LHL009, which is available from the Company, marked "External Review Request" to the Appeals Coordinator of USABLE Mutual Insurance Company, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203. Alternatively, you may e-mail your request to APPEALSCOORDINATOR@USABLEMUTUAL.COM. Your request may be made after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.4.1.b.ii. applies, your request may be made at the end of the thirty (30) day period following the Appeals Coordinator's receipt of your appeal.

3. **Written Appeals.** You must submit your appeal in writing via mail or e-mail. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
4. **Independent Review Organization and Independent Medical Reviewer**
 - a. **The Company** shall select an Independent Review Organization from the list of registered Independent Review Organizations compiled and maintained by the Texas Department of Insurance.
 - b. **The Independent Review Organization** is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
 - c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with the Plan Administrator, with an officer or director of the Company or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.
5. **Referral of Review Request to an Independent Review Organization.** Within three (3) business days after the Company receives your request for external review, the Appeals Coordinator shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to the Independent Review Organization. The Company will provide the Independent Review Organization designated by the Company with a copy of: (a) any medical records of the enrollee that are relevant to the review; (b) any documents used by the plan in making the determination to be reviewed; (c) any documents and other written information in support of the appeal. A list of each Physician or other health care provider who (1) has provided care to You and (2) who may have medical records relevant to the appeal.
6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal.
7. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.4.7 or 7.4.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).
8. **Timing of Appeal Determination.**
 - a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than twenty (20) days after the Independent Review Organization received the appeal.
 - b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall

make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received information necessary to make a determination.

9. **Notification of Determination of Independent Medical Review.**

- a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Texas Department of Insurance.
- b. **The Notification shall include.**
 - i. a general description of the reason for the request for external review;
 - ii. the date the Independent Review Organization was notified by the Company to conduct the review;
 - iii. the date of the Independent Medical Reviewer's determination;
 - iv. the principal reason(s) for the determination;
 - v. the rationale for the determination;
 - vi. references to the evidence or documentation, including practice guidelines, considered in the determination; and
 - vii. any other items as required by applicable federal and state law.

10. **Expedited External Review.**

- a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review if You, your Authorized Representative (see Subsection 7.5) or your Physician of record determines that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
- b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.4.9 whether you will be required to complete the internal review process.
- c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.4 applicable to independent medical review of claims apply to expedited external review of claims.

11. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

12. **Assistance.** If you have any questions concerning the External Review Process, you may contact the Appeals Coordinator, USABLE Mutual Insurance Company, Post Office Box 1151, 320 West Capitol, Suite 500, Little Rock, Arkansas 72203. Telephone (501) 378-2025.

13. **Texas Department of Insurance.** You may contact the Texas Department of Insurance for assistance. The mailing address is Texas Department of Insurance, 333 Guadalupe, P.O. Box 149104, Austin, Texas 78714. The telephone number is toll free 866-554-4926.

14. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on the Plan, except to the extent that other remedies are available under applicable federal or state law.

7.5 **Authorized Representative**

- 1. **One Authorized Representative.** A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.

2. **Authority of Authorized Representative.** An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to "You" or "Covered Person" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative.** One of the following persons may act as a Covered Person's Authorized Representative:
 - a. An individual designated by the Covered Person in writing in a form approved by the Company;
 - b. The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Company;
 - c. A person holding the Covered Person's durable power of attorney;
 - d. If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
 - e. If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Company is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.
4. **Communication with Authorized Representative.**
 - a. If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
 - b. If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
 - c. If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Company will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Company will provide copies of such correspondence to the Authorized Representative upon request.
5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until
 - a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or
 - b. the Covered Person is legally competent to represent himself or herself and notifies the Company that the Authorized Representative is no longer required.

8.0 OTHER PROVISIONS

The following information is important in the administration of the Plan.

- 8.1 **Payment of Benefits.** Benefits payable under this Benefit Certificate shall be paid to the Covered Person or to the Covered Person's assignee.
- 8.2 **Right of Rescission.** Fraudulent or intentional material misrepresentation, misstatements or omissions of information may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependent.
- 8.3 **Claim Recoveries.** There may be circumstances in which the Company recovers amounts paid as claims expense from a Provider of services, from a Covered Person or from a third party. Such

circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care Providers or pharmaceutical manufacturers through certain legal actions instituted by the Company relating to the claims expense of more than one Covered Person, recoveries by the Company of overpayments made to health care Providers or to Covered Persons, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Covered Person and the Company shall be entitled to retain such recoveries for its own use.
If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Covered Person will be adjusted if affected by the recovery.
 2. Only recoveries made within two years of the date of the error by the Company or overpayments to health care Providers or to Covered Persons by the Company will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.
 3. In the event the Company receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, the Company shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Covered Person.
 4. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
 5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Covered Person and the Company shall be entitled to retain such recovery for its own use.
- 8.4. **Amendment.** The Company reserves the right to change the benefits, conditions and premiums covered under the Group Policy or Group Insurance Contract, including the terms of this Benefit Certificate. If we do so, we will give sixty (60) days written notice to your Employer or its agent and the change will go into effect on the date fixed in the notice. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this Benefit Certificate. Any change or amendment must be in writing and signed by an officer of the Company.

9.0 GLOSSARY OF TERMS

These are terms used in this Group Policy and Benefit Certificate.

- 9.1 **Accidental Injury** is defined as bodily injury (other than intentionally self-inflicted injury) sustained by a Covered Person while the insurance is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an Accidental Injury.
- 9.2. **Acquired Brain Injury** means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.
- 9.3 **Allowable Charge** is the maximum amount determined by the Company for a particular Covered Service, equipment, or supply.
 1. For services provided by a Preferred Provider, the Allowable Charge is dictated by the terms of the provider contract.
 2. For services provided by a Non-preferred Provider when a Preferred Provider is reasonably available, the Allowable Charge shall be the amount deemed by the Company to be reasonable. The USAble Mutual Insurance Company customary allowance is the basic Allowable Charge. Allowable Charge may vary, however, given the facts of the case and the opinion of the Company's medical director. See Subsection 3.3 with respect to Allowable Charge for

Ambulatory Surgery Centers. See Subsection 3.23.4 with respect to Allowable Charge for transplants.

3. For services provided by a Non-preferred Provider (i) for Emergency Care; (ii) when no Preferred Provider is reasonably available within the service area; or (iii) when the services of the Non-preferred Provider were pre-approved by the Company based upon the unavailability of a Preferred Provider, the Allowable Charge shall be the lesser of:
 - a. the provider's billed charge; or
 - b. the usual, customary, or reasonable charge for the service, based on generally accepted practices for determining the customary billed charge for the service that fairly and accurately reflects market rates, including geographic differences in costs. The source of the usual, customary, and reasonable charge is from statistically valid claims data from the geographic area where the service is provided. This data is updated no less than once per year. However, in the event the Company is unable to determine the usual, customary, or reasonable charge for the claimed service, the Allowable Charge will be the provider's billed charge.

Please Note: All benefits under this Benefit Certificate are subject to and shall be paid only by reference to the Allowable Charge.

1. If you receive covered services from a Preferred Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance, and any non-covered services; however, if you use a Non-preferred Provider, for services not covered by subparagraph 3 above, you will be responsible for all amounts billed in excess of the Allowable Charge.
2. Claims paid under subparagraph 3 above shall be paid at the applicable In-Network Copayment or Coinsurance level. In addition, the Company will credit to the Deductible and to the Annual Limit on Cost Sharing any out-of-pocket amounts you paid to the Non-Preferred Provider for charges for covered services beyond the Allowable Charge.

9.4 **Ambulance Service** means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the specific Benefit Certificate limitation applied to ambulance benefits per calendar year.

9.5 **Ambulatory Surgery Center** means a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

9.6 **Annual Limitation on Cost Sharing** means the amount of Allowance or Allowable Charges a Covered Person must incur for claims in a calendar year before the Covered Person is relieved of the obligation to pay Copayments, Deductible or Coinsurance for the remainder of the calendar year. The Annual Limitation on Cost Sharing is set forth in the Schedule of Benefits.

9.7 **Approved Clinical Trial** means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is approved by:

1. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United States Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

9.8 **Benefit Certificate** means this certificate of insurance containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of the Company.

9.9 **Brand Name Medication** means any Prescription Medication that has a patented trade name separate from its generic or chemical designation.

9.10 **Case Management** is a program in which a registered nurse employed by US Able Mutual Insurance

Company, known as a Case Manager, assists a Covered Person through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Covered Person. Case management is instituted at the sole option of the Company when mutually agreed to by the Covered Person and the Covered Person's Physician.

- 9.11 **Chemical Dependency** means the abuse of a psychological or physical dependence on or addiction to alcohol or a Controlled Substance (as defined).
- 9.12 **Chemical Dependency Treatment Center** means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:
- a. affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
 - b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
 - c. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
 - d. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.
- 9.13 **Chemotherapy** means Chemotherapy for the treatment of a malignant neoplastic disease by chemical agents that affect the disease causing agent unfavorably. High dose Chemotherapy is Chemotherapy several times higher than the standard dose for malignant disease (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient who received this high dose Chemotherapy, to prevent life-threatening complications of the Chemotherapy on the patient's own progenitor blood cells.
- 9.14 **Child** means an Employee's natural Child, legally adopted Child or Stepchild. "Child" also means a Child to whom a Covered Person is a party in a suit for adoption. "Child" also means a Child for whom the Employee must provide medical support under a qualified medical child support order or for whom the Employee has been appointed the legal guardian.
- 9.15 **Childhood Immunizations** means a test for tuberculosis, immunization and re-immunization against diphtheria, pertussis, tetanus, poliomyelitis, Hemophilus influenzae type b, measles, mumps, rubella, varicella, and hepatitis B, or any other immunization required by law for the Child.
- 9.16 **Cognitive Communication Therapy** means services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information. Services or supplies provided as, or in conjunction with, Cognitive Communication Therapy are not covered, except for the diagnosis of Acquired Brain Injury. See Subsections 3.30 and 4.2.17.
- 9.17 **Cognitive Rehabilitation Therapy** means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.. Services or supplies provided as, or in conjunction with, Cognitive Rehabilitation Therapy are not covered, except for the diagnosis of Acquired Brain Injury. See Subsections 3.30 and 4.2.18.
- 9.18 **Coinsurance** means the obligation of a Covered Person to pay a certain portion of an Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from a Preferred Provider and the Coinsurance for services and supplies from Non-Preferred Provider.
- 9.19 **Company** means USABLE Mutual Insurance Company.
- 9.20 **Complication of Pregnancy** means
1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilatation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition

manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this subsection, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP, syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hydatidiform mole or ectopic pregnancy.
3. Management of a difficult pregnancy is not a Complication of Pregnancy.

9.21 **Compound Medication** means a non FDA approved medication prescribed by a Physician that is admixed by a pharmacist using multiple ingredients which may or may not be FDA approved individually. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are not Compound Medications.

9.22 **Cosmetic Service** means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy eligible for coverage under this Benefit Certificate: (a) reconstruction of the breast on which the surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures are not considered Cosmetic Services: correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma on the head, neck, or face.

9.23 **Coverage Policy** means a statement developed by the Company that sets forth the medical criteria for coverage under a US Able Mutual Insurance Company benefit certificate or insurance policy. Some limitations of benefits related to coverage, of a drug, treatment, service equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from the Company, at no cost, upon request by contacting Customer Service.

9.24 **Covered Person** means an Employee or Dependent who is insured under this policy.

9.25 **Covered Services** means services for which a Covered Person is entitled to benefits under the terms of this Group Policy and Benefit Certificate.

9.26 **Craniofacial Abnormality** means an abnormal structure of the face caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

9.27 **Crisis Stabilization Unit** means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

9.28 **Custodial Care** means care rendered to a Covered Person (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial determination is not precluded by the fact that a Covered Person is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the Covered Person's condition, or provide for the Covered Person's comfort, or ensure the manageability of the Covered Person. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N. or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a skilled nursing facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Covered Person; it only means that it is a type of care that is not covered under this Benefit Certificate.

9.29 **Deductible** means the amount of out of pocket expense a Covered Person must incur for Covered

Services each calendar year before any expenses subject to Coinsurance are paid by the Company under the Plan. This amount is calculated from Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations and exclusions in the Plan, payment of Coinsurance for Covered Services begins.

- 9.30 **Dental Care** means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural, and shall include any Hospital services and administration of anesthetic in connection with any of the foregoing.
- 9.31 **Dependent** means any member of an Employee's family who meets the eligibility requirements of Section 6.0, who is enrolled in the Group, and for whom the Company has received premium.
- 9.32 **Diabetes Self-Management Training** means (1) the training provided to a Covered Person after the initial diagnosis of diabetes in the care and management of that condition (including nutrition counseling and proper use of diabetes equipment and supplies); (2) additional training authorized on the diagnosis of a Physician or Health Care Provider of a significant change in the Covered Person's symptoms or condition that requires changes in the Covered Person's self-management regime; and (3) periodic or episodic continuing education training when prescribed by a Health Care Provider as warranted by the development of new techniques and treatments for diabetes.
- 9.33 **Dose Limitation** means a limitation in the number of doses of a Prescription Medication in a single prescription or a limit in the number of doses over a defined period of time. For example, a Dose Limitation for a particular medication may be set at no more than 10 doses in a dispensed prescription and no more than 20 doses during a 30-day period.
- 9.34 **Durable Medical Equipment (DME)** means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home.
- 9.35 **Eligibility Date** means:
For an Employee, the latest of the following dates:
 1. the policy effective date for an Employee who has selected coverage and is working for the Employer on that date; or
 2. the date the required Waiting Period is completed for any Employee hired after the policy effective date.
For a Dependent, the latest of the following dates:
 1. the date the Employee becomes eligible for coverage under the Plan;
 2. the date a person becomes a Dependent; or
 3. the date this policy is amended to include the Employee's class as being eligible for Dependent coverage.
- 9.36 **Emergency Care** means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious disfigurement; or (v) in the case of a pregnant women, serious jeopardy to the health of the fetus.
- 9.37 **Employee** means a person who is directly employed by the Employer for Full-Time Employment. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under the health benefit plan.
- 9.38 **Employer** means a sole proprietorship, partnership, or corporation which is the Policyholder. Employer, Group, Member and Policyholder shall have a common meaning when used herein.
- 9.39 **Formulary** means a specified list of Prescription Medications covered by the Company. The services of an independent National Pharmacy and Therapeutics Committee (P&T Committee) are utilized to approve safe and clinically effective drug therapies on the Formulary. The P&T Committee is an external advisory body of experts from across the United States. The P&T Committee's voting

members include physicians, pharmacists, a pharmacoeconomist, and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs.

Prescription Medications on the Formulary are classified into various cost tier designs based on the benefit. Prescription Medication tiers are classified as Preventive Medications, Generic Medications, Brand Name Medications, and Specialty Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by the Company and the Pharmacy and Therapeutics Committee. In recommending whether to place a Prescription Medication on the Formulary or to place a Prescription Medication in a tier classification in the Formulary, the Pharmacy and Therapeutics Committee compares a Prescription Medication's safety, effectiveness, cost efficiency and uniqueness with other Prescription Medications in the same category. **Prescription Medications including new Prescription Medications approved by the FDA are not covered under this Benefit Certificate unless or until the Company places the medication on the Formulary.** A list of Medications on the Formulary is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.USABLEMUTUAL.COM. The Company will disclose on request whether a specific Medication is included in the Formulary. Of course, the fact that a Medication is on the Formulary is no guarantee that your Provider will prescribe it.

- 9.40 **Freestanding Facility** means an entity that furnishes health care services and that is neither integrated with, nor a department of, a Hospital. Physically separate facilities on the campus of a Hospital are considered freestanding unless they are integrated with, or a department of, the Hospital. Examples of Freestanding Facilities include, but are not limited to, Free-Standing Cardiac Care Facilities and Free-Standing Residential Treatment Centers. Ambulatory Surgery Centers performing covered services provided in 3.3 are not considered Freestanding Facilities. Laboratories are not considered Freestanding Facilities.
- 9.41 **Full-Time Employment**, full-time active Employee, and like terms, mean a job with the Employer:
1. on a permanent and active basis (not related to health status related factors); and
 2. usually for at least thirty (30) hours a week.
- 9.42 **Generic Medication** means any US Food and Drug Administration ("FDA") approved, chemically identical, reproduction of a Brand Name Medication for which the patent has expired. A Prescription Medication must have a price at least twenty percent (20%) lower than the Brand Name Medication in order to qualify as a Generic Medication for reimbursement purposes.
- 9.43 **Group Policy or Group Insurance Contract** means the insurance policy issued by the Company to the Employer.
- 9.44 **Health Care Provider** (other than a Physician or a Hospital) means a Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Chiropractic, Licensed Dentist, Licensed Audiologist, Licensed Speech-Language Pathologist, Licensed Master Social Worker, Licensed Dietitian, Certified Registered Nurse Anesthetist, Licensed Professional Counselor, Psychologist, Licensed Marriage and Family Therapist, Licensed Hearing Aid Fitter and Dispenser, Chemical Dependency Counselor, Occupational Therapist, Licensed Psychological Associate, Licensed Acupuncturist, Licensed Surgical Assistant or a Licensed Physical Therapist. This term also means an Advanced Practice Nurse, a Nurse First Assistant or a Physician Assistant when authorized to provide care by a Physician.
- 9.45 **Health Intervention or Intervention** means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.
- 9.46 **Hospice Care** means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient and home-like inpatient care for the terminally ill patient and family. Hospice Care provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.
- 9.47 **Homeopathic** means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet therapy, environment services and minimum doses of natural medications. Homeopathic treatments are not covered. See Subsection 4.2.69.
- 9.48 **Hospital** means an acute general care Hospital, a Psychiatric Hospital and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless

required by applicable law or approved by the Board of Directors of the Company: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

- 9.49 **Laboratory** means an entity furnishing biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in the body. Entities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.
- 9.50 **Late Enrollee** means a Covered Person who submits an application for coverage other than during:
1. the first period in which the Covered Person is eligible to enroll in the Plan; or
 2. a Special Enrollment Period.
- 9.51 **Life-Threatening** means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- 9.52 **Low-Dose Mammography** means
- a. the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast;
 - b. digital mammography; or
 - c. breast tomosynthesis, which means the radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.
- 9.53 **Low Protein Modified Food Products** means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of phenylketonuria, galactosemia, organic acidemias fatty acid and oxidative disorders, and disorders of amino acid metabolism.
- 9.54 **Maintenance Medication** means a specific Prescription Medication: (1) for ongoing therapy of a chronic illness; and (2) that has been designated as a Maintenance Medication by the Company. You may obtain a list of Maintenance Medications by calling Customer Service.
- 9.55 **Maintenance Therapy** means any therapy where there is no expectation based upon a reasonable degree of medical probability that treatment will result in significant, measurable improvement in the condition in a reasonable, predictable period of time for treatment.
- 9.56 **Maternity Care and Obstetrical Care** means health interventions necessary because of or related to the following conditions: premature rupture of membranes; false labor; occasional spotting in pregnancy; pre-term labor; pre-term birth; physician prescribed rest during the pregnancy; morning sickness; hyperemesis gravidarum; cephalopelvic disproportion; intrauterine growth retardation; analysis for fetal down syndrome, trisomy 18 or neural tube defect; congenital diaphragmatic hernia; hydrops fatalis; group B strep prophylaxis in pregnancy; isoimmunization in pregnancy; antepartum fetal surveillance; management of hyperemesis; cervical incompetence; fetal urethral obstruction; twin or greater gestation with prior uterine atony; macrosomia; incompetent cervix; forceps deliver; fetal fibronectin; cytotec for induction of labor; sudden onset of polyhydramnios; prophylactic cesarean delivery of HIV positive mother; Klippel-Trenaunay Syndrome; caudal regression syndrome; hospitalization to postpone delivery until the fetus is further developed; biophysical profiles; fetal monitoring; non-routine ultrasounds; vaginal delivery; antepartum and postpartum care; or services related to c-sections scheduled because of (a) multiple gestation, (b) previous c-section delivery, (c) patient or physician convenience, (d) cephalopelvic disproportion or (e) abnormal presentations such as breech, shoulder dystonia, transverse and compound.
- 9.57 **Medical Food** means a food that is intended for the dietary treatment of phenylketonuria, galactosemia, organic acidemias fatty acid and oxidative disorders, and disorders of amino acid metabolism for which

nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

- 9.58 **Medical Literature** means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended.
- 9.59 **Medical Supply or Supplies** means an item which (1) is consumed or diminished with use so that it cannot withstand repeated use; and (2) is primarily or customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury.
- 9.60 **Medicare** means the two programs cited as the "Health Insurance for the Aged Act," Title I, Part I, of Public Law 89-97, as amended. Part A refers to Hospital insurance. Part B refers to supplementary medical insurance.
- 9.61 **Naturopathic** means a system of therapeutics in which neither surgical or medicine agents are used, dependence placed only on natural (non-medicinal) focus. Naturopathic treatments are not covered. See Subsection 4.2.69.
- 9.62 **Neurobehavioral Testing** means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- 9.63 **Neurobehavioral Treatment** means interventions that focus on behavior and the variables that control behavior.
- 9.64 **Neurocognitive Rehabilitation** means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- 9.65 **Neurocognitive Therapy** means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- 9.66 **Neurofeedback Therapy** means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- 9.67 **Neurophysiological Testing** means an evaluation of the functions of the nervous system.
- 9.68 **Neurophysiological Treatment** means interventions that focus on the functions of the nervous system.
- 9.69 **Neuropsychological Testing** means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- 9.70 **Neuropsychological Treatment** means interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- 9.71 **Non-Diseased Tooth** means a tooth that is whole or properly restored, and is free of decay and/or periodontal conditions.
- 9.72 **Non-Preferred Provider** means a Provider that does not participate in the Preferred Provider Organization.
- 9.73 **Orthotic Device** means a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body.
- 9.74 **Outpatient Hospital** means a portion of a Hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, a Physician to patients treated on an outpatient basis for a variety of medical conditions and not kept overnight or otherwise admitted as inpatients to the Hospital.
- 9.75 **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such by the appropriate state agency.
- 9.76 **Outpatient Therapy Visit** means one unit of therapeutic service (usually one hour or less) provided by licensed Provider(s). An Outpatient Therapy Visit may include services provided by more than one Provider and in the case of physical therapy, up to four modalities of treatment. Any physical therapy or occupational therapy modality, regardless of who provides the service, is included in the visit limit. Outpatient therapy visit applies to therapy provided in a physician's office or in a physical therapy setting.
- 9.77 **Partial Hospitalization** means continuous treatment for a Covered Person who requires care or

- support, or both, in a Hospital but who does not require 24-hour supervision. A Physician must prescribe services for at least 4 hours, but not more than 16 hours in any 24-hour period.
- 9.78 **Participating Pharmacy** means a licensed pharmacy that has contracted directly or indirectly with the Company to provide pharmacy services to Covered Persons subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate.
- 9.79 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered.
- 9.80 **Physician Service** means such services as are rendered by a licensed Physician within the scope of his license.
- 9.81 **Placement, or being placed, for adoption** means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.
- 9.82 **Plan** means the Employee health benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Policy or Group Insurance Contract between the Company and your Employer.
- 9.83 **Plan Administrator** means the Employer.
- 9.84 **Plan Year** means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Policy.
- 9.85 **Policy** means the Group Policy or Group Insurance Contract.
- 9.86 **Policy Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by the Company.
- 9.87 **Policyholder** means the Employer that established and maintains the Plan, as shown in the Application of the Group Insurance Policy.
- 9.88 **Post-acute Transition Services** means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- 9.89 **PPO Service Area** means the geographical area in which Preferred Providers have contracted with the Company. The PPO Service Area is the State of Arkansas and the following counties in Northeast Texas: Bowie, Camp, Cass, Gregg, Harrison, Lamar, Marion, Morris, Red River, Titus and Upshur.
- 9.90 **Pre-admission Notification** means alerting the Company of an admission to an Out-of-Network Hospital, a Long Term Acute Care Hospital or to a Long Term Acute Care division of a Hospital. Pre-admission Notification does not represent Preauthorization for the admission.
- 9.91 **Preauthorization** means the process by which the Company determines in advance of the Covered Person obtaining a requested medical service, Medication, supply, test or equipment that such medical service, Medication, supply, test or equipment meets Primary Coverage Criteria. Ongoing therapy of a prior authorized Medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy. **Please note that if the Company gives Preauthorization for a Health Intervention, that only means that the Company will not deny or reduce payment to the Physician or Health Care Provider for those services based upon Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f., unless the Physician or Health Care Provider has materially misrepresented the proposed Health Intervention or has substantially failed to perform the proposed Health Intervention. Even when Preauthorization is obtained, the Preauthorization does not guarantee payment. The Health Intervention may still be denied based upon one of the other terms, conditions, exclusions or limitations of the Plan as set forth in this Benefit Certificate. Failure to preauthorize will result in a 50% reduction in payment of the claim.**
- 9.92 **Preferred Provider** means a Provider who has signed a contract with the Company to provide the services covered by this Benefit Certificate to Company Benefit Certificate holders and who has agreed to participate in the Preferred Provider Organization, directly or indirectly, and meets all applicable credentialing and contractual standards associated with the Preferred Provider Organization.

- 9.93 **Preferred Provider Organization** means a panel of Providers (Hospitals and Physicians) who have agreed to accept reimbursement for their services covered under this Plan at reduced charges.
- 9.94 **Prescription** means an order for Medications by a Physician or health care Provider authorized by applicable law to issue a Prescription, to a pharmacy for the benefit of and use by a Covered Person.
- 9.95 **Prescription Medication** or **Medication** means any pharmaceutical that has been approved by the FDA and can be obtained only through a Prescription. The Company has classified selected Prescription Medications, primarily Medications intended for self-administration as “A Medications.” The Company has classified Intra-muscular injections, Intravenous injections and other pharmaceuticals that are primarily intended for professional administration as “B Medications.” You can determine whether a Medication is an A Medication or a B Medication by contacting Customer Service.
- 9.96 **Prosthetic Device** means an artificial device that replaces a missing body part, which may be lost through trauma, disease, surgery, or congenital conditions.
- 9.97 **Psychiatric Conditions** means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and Psychiatric Conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)
- 9.97 **Psychiatric Residential Treatment Center** means a facility, or a distinct part of a facility, for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
- 9.98 **Reconstructive Surgery for Craniofacial Abnormalities** means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.
- 9.99 **Relevant to the Claim** means a document, record or other information that:
1. was relied upon in making the benefit determination;
 2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 3. demonstrates compliance with the administrative processes and safeguards required by 7.2.5.b.; and
 4. constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Covered Person’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- 9.100 **Remediation** means the process(es) of restoring or improving a specific function.
- 9.101 **Residential Treatment Center for Children and Adolescents** means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.
- 9.102 **Retransplantation** means a second transplant performed within sixty (60) days of the failure of an initial transplant.
- 9.103 **Routine Patient Costs** in connection with an Approved Clinical Trial mean the costs for health interventions covered by the Plan except:
1. the investigational item, device or service, itself;
 2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the individual undergoing the clinical trial; or
 3. a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.
- 9.104 **Routine Prenatal Care** means outpatient antepartum care and Laboratory testing that has been approved as routine based on a Coverage Policy established by the Company. A copy of the Routine Prenatal Care Coverage Policy is available from the Company, at no cost, upon request by contacting Customer Service.

- 9.105 **Screening Test** means a test used to detect an undiagnosed disease in an individual who has neither symptoms, findings nor any past history of the specific disease for which the Screening Test is being performed.
- 9.106 **Serious Mental Illness** means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):
- a. schizophrenia;
 - b. paranoid and other psychotic disorders;
 - c. bipolar disorders (hypomanic, manic, depressive and mixed;)
 - d. major depressive disorders (single episode or recurrent);
 - e. schizo-affective disorders (bipolar or depressive);
 - f. pervasive developmental disorders;
 - g. obsessive-compulsive disorders; and
 - h. depression in childhood and adolescence.
- 9.107 **Skilled Nursing Facility** means an institution licensed as such by the appropriate state agency. A Skilled Nursing Facility must:
1. be operated pursuant to law;
 2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
 3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician (M.D. or D.O.);
 4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and
 5. maintain a daily medical record of each patient.
- However, a Skilled Nursing Facility does not include:
1. any home, facility or part thereof used primarily for rest;
 2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
 3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or Custodial Care or educational care.
- 9.108 **Special Circumstances** means a condition such that the treating Provider reasonably believes that discontinuing care by the Provider could cause harm to the Covered Person.
- 9.109 **Special Enrollment Period** means a thirty-one (31) day period during which time an Employee or Employee's Dependent may enroll in the Plan, after his or her initial Waiting Period (Eligibility Period or Eligibility Date) and not be a Late Enrollee. Special Enrollment Periods occur in two instances:
1. **AFTER THE TERMINATION OF ANOTHER HEALTH PLAN:** A Special Enrollment Period occurs (i) after an Employee's or Dependent's coverage under another health plan terminated as a result of Loss of Eligibility; (ii) the Employee elects a different benefit package at Open Enrollment or (iii) after the employer providing such other health Plan terminated its contributions.
 2. **AFTER THE ADDITION OF A DEPENDENT:** A Special Enrollment Period occurs for an Employee, Employee's Spouse or Employee's new Dependent Child (i) after the Employee marries; (ii) after an Employee's Child is born; (iii) after a court has ordered coverage for an Employee's Spouse or (iv) an Employee adopts a Child or becomes a party in a suit for the adoption of a Child.
- 9.110 **Spouse** means an individual who is the husband or wife of an Employee as a result of a marriage that is legally recognized in a jurisdiction within the United States of America.
- 9.111 **Step Therapy** means a process that establishes a required order of use for a specific Prescription Medication. For example, a Step Therapy may require that medication "X" be used for a period of time before medication "Y" or that a weaker strength of a medication be used for a period before a stronger strength of the same medication.
- 9.112 **Stepchild** means a natural or adopted Child of the Spouse of the Employee.
- 9.113 **Substance Use Residential Treatment Center** means a facility that provides treatment for substance (alcohol and drug) use to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, Laboratory tests, drug and supplies,

psychological testing, and room and board.

- 9.114 **Telehealth** means a Health Intervention, other than Telemedicine, delivered by a health professional licensed, certified, or otherwise entitled to practice in the State of Texas and acting with the scope of the health professional's license, certification, or entitlement to the Covered Person at a different physical location than the health professional using telecommunication or information technology.
- 9.115 **Telemedicine** means a Health Intervention delivered by a Physician licensed in the State of Texas, or a health professional acting under the delegation and supervision of a Physician licensed in the State of Texas and acting with the scope of the Physician's or health professional's license to a Covered Person at a different physical location than the Physician or health professional using telecommunications or information technology.
- 9.116 **Transplant Global Period** means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.
- 9.117 **Waiting Period** means the time beginning with the Employee's most recent date of continuous employment with the Employer and ending on the date he is eligible for insurance. The Employer establishes the Waiting Period, but for purposes of coverage or eligibility determinations under this Benefit Certificate, the Waiting Period shall be such period as is reflected in the enrollment records of the Company. Waiting Period shall not exceed ninety (90) days.
- 9.118 **We, Our and Us** mean the Company.
- 9.119 **Work Hardening** means a highly specialized rehabilitation program that spans the transition from traditional rehabilitation therapies to return to work by simulating the workplace activities and surroundings in a monitored environment. Programs may be developed and carried out by an occupational therapist and/or physical therapist. The goal is to create an environment in which returning workers can rebuild psychological self-confidence and physical reconditioning by replicating their work routine.
- 9.120 **Work Integration (Community)** means training in shopping, transportation, money management, vocational activities and/or work environment/modification analysis, and/or work task analysis. This is not considered medical treatment.
- 9.121 **You and Your** mean a Covered Person.

10.0 YOUR RIGHTS UNDER ERISA

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This information and the information contained in this Benefit Certificate, constitute the Summary Plan Description required by ERISA.

10.1 Information about the Plan

As a participant in the Plan described in this Benefit Certificate, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all plan documents, including insurance company contracts, and copies of all documents filed by the plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.
2. Obtain copies of all applicable plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

10.2 Continuation of Coverage

The Plan provides an opportunity to continue coverage for yourself, spouse, dependents if there is a loss of coverage under the Plan as a result of a qualifying event. See Subsection 6.4.3.a. You or your dependents may have to pay for such coverage. Review this Benefit Certificate, Subsection 6.4.3 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

10.3 Creditable Coverage

The Plan provides a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health

insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment in your coverage.

10.4 **Prudent Actions by Plan Fiduciaries**

1. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.
2. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a benefit or exercising your rights under ERISA.

10.5 **Enforce your Rights**

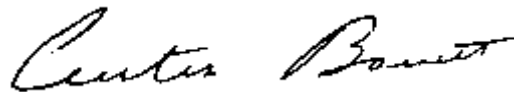
1. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees for example, if it finds your claim is frivolous.

10.6 **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

10.7 **Claim and Appeal Procedures**

The Plan rules and procedures for filing claims and seeking review of adverse claim determinations are set forth in Section 7.0 of this Benefit Certificate.



Curtis Barnett, President and Chief Executive Officer

USABLE MUTUAL INSURANCE COMPANY
601 S. Gaines Street
LITTLE ROCK, ARKANSAS 72201