Funded by the University of Colorado Health and Welfare Trust

Health Plan

Global Expat

A guide to your benefits

2027



4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, PA 19406

SCHEDULE OF BENEFITS
Policyholder: The Regents of the University of Colorado, a body corporate and state institution of higher education of the State of Colorado
Effective Date: January 1, 2027

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
The Percentage of Covered Expenses the Covered Person Pays	0%	0%	20% of the Allowed Amount	
	See the Cost-Sharing and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Providers charge that exceeds Our Allowed Amount.			
Policy Year Medical Deductible				
• Individual	$350	$350	$500	
• Family	$1,050	$1,050	$1,500	
Policy Year Medical Out-of-Pocket Limit				
• Individual	$6,500	$6,500	$10,000	
• Family	$13,000	$13,000	$20,000	
	Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.			
OFFICE VISITS				
Primary Care Office Visits	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Specialist Office Visits	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Telehealth Services billed by a Provider	Covered the same as an Office Visit	Covered the same as an Office Visit	Covered the same as an Office Visit	
Virtual Telehealth using Global TeleMD™ smartphone app	Covered in full	Covered in full	Covered in full	

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
PREVENTIVE CARE – See benefit for description				
• **Well Child Care Visits***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Child Immunizations***	Covered in full	Covered in full	Covered in full	
• **Lead Poisoning Screening Tests**	Covered in full	Covered in full	20% Coinsurance after Deductible	For Children under the age of 6
• **Adult Annual Physical Examinations***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Adult Immunizations***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Travel Immunizations**	Covered in full	Covered in full	Covered in full	Policy Year Maximum of $500
• **Routine Gynecological Services/Well Woman Exams***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Sterilization Procedures for Women***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Screening for Colon Cancer***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Vasectomy**	Covered Same as any other medical condition based on place of service	Covered Same as any other medical condition based on place of service	Covered Same as any other medical condition based on place of service	
• **Bone Density Testing***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **Screening for Prostate Cancer***	Covered in full	Covered in full	20% Coinsurance after Deductible	
• **All other preventive services required by USPSTF and HRSA.**	Covered in full	Covered in full	20% Coinsurance after Deductible	
* When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
EMERGENCY CARE				
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Emergency Ambulance Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	0% Coinsurance after Deductible	$250 Copayment and then 0% Coinsurance, not subject to Deductible	$250 Copayment and then 0% Coinsurance, not subject to Deductible	
Non-Emergency Use of the Emergency Department Copayment waived if admitted to Hospital	0% Coinsurance after Deductible	$250 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
Urgent Care Center	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE				
Acupuncture or Acupressure	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	Limited to 20 visits per Policy Year
Advanced Imaging Services **Preauthorization Required**				See benefit for description
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Allergy Testing and Treatment				See benefit for description
• Performed in a PCP Office	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
• Performed in a Specialist Office	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
Ambulatory Surgical Center Facility Fee	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Anesthesia Services (all settings)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation				
• Performed in a Specialist Office	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	
Chemotherapy and Immunotherapy				
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed at Home	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Chiropractic Services	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	Limited to 20 visits per Policy Year
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing				
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Dialysis				
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed in a Freestanding Center	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed at Home	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Gender Reassignment Surgery **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description and any limitations
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)				
• Performed in a PCP Office	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	60 visits per Policy Year combined therapies.
• Performed in a Specialist Office	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
• Performed in an Outpatient Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Home Health Care **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to 120 visits per Policy Year
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description and any limitations.
Infusion Therapy				See benefit for description
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed in Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Home Infusion Therapy	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy				
• Medically Necessary Abortions	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Elective Abortions	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Laboratory Procedures				
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Laboratory Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Maternity and Newborn Care Preauthorization Required				See benefit for description
• Prenatal Care				
– Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	20% Coinsurance after Deductible	
– When Prenatal Care is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	
• Inpatient Hospital Services and Birthing Center	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	Covered in full	20% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Services of a Doula	0% Coinsurance after Deductible	Not Covered	Not Covered	In home or facility up to 10 visits (pre and post-natal combined)
Outpatient Hospital Surgery Facility Charge	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Preadmission Testing	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities **Preauthorization required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services				
• Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Therapeutic Radiology Services				
• Performed in a Specialist Office	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)				
• Performed in a PCP Office	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	60 visits per Policy Year combined therapies.
• Performed in a Specialist Office	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
• Performed in an Outpatient Facility	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Retail Health Clinic Care	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	
Second Opinions on the Diagnosis of Cancer, Surgery and Other Cases	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) **Preauthorization Required**				See benefit for description
• Inpatient Hospital Surgery	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Outpatient Hospital Surgery	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Office Surgery	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES				
Diabetic Equipment, Supplies and Self-Management Education				See benefit for description
• Diabetic Equipment and Supplies	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Diabetic Education	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Durable Medical Equipment and Braces	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Hearing Examination	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	One Examination per 24 month period
Pediatric Hearing Aid and Cochlear Implant	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) per year per time Covered
Adult External Hearing Aids	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Single purchase once every 36 months and limited to $1,000 per hearing aid
Hospice Care **Preauthorization Required**				Five (5) visits for family bereavement counseling
• Inpatient	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Outpatient	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Medical Supplies	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Nutritional Evaluation	0% Coinsurance after Deductible	$40 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.
Nutritional Formulas	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Private Duty Nursing	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to 120 visits per Policy Year
Prosthetic Devices				One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements
• External	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Internal	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited; See benefit for description
• Wigs (for hair loss due to alopecia areata or cancer treatment	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Policy Year Maximum of $500
Temporomandibular joint dysfunction (TMJ)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	
INPATIENT SERVICES and FACILITIES				
Autologous Blood Banking	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Observation Stay	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to 120 days per Policy Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to 120 days per Policy Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Limited to 120 days per Policy Year
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES (*All mental health and substance use benefits will be paid at the same level of coinsurance as any other illness/injury)*				
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	0% Coinsurance after Deductible	$30 Copayment and then 0% Coinsurance, not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

	International (Outside of the United States)	U. S. Participating Provider	U. S. Non-Participating Provider	Limits
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) **Preauthorization Required**	0% Coinsurance after Deductible	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited; Up to 20 visits per Policy Year may be used for family counseling

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services

Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for You and Your insured Dependents. The Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the Schedule of Benefits and as described in the Prescription Drug Coverage section of this Certificate. To receive Prescription Drug Benefits, You and Your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments. Your Cost Sharing will never exceed the Usual and Customary Charge of the Prescription Drug. Benefits are limited as described in the Prescription Drug section of this Certificate and are subject to the Medical "Exclusions" section of this Certificate.

The following are applicable to all Prescription Drug benefits:

- The Prescription drug designation is as per generally-accepted industry sources and adopted by Us and is subject to change.
- The maximum out-of-pocket costs for prescription insulin drugs shall not exceed $100 per 30-day supply, regardless of the amount or type of insulin that is needed to fill such member's prescription.
- Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.

Prescription Drugs Purchased Outside of the United States

Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply	
Generic Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.
Preferred Brand Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.
non-Preferred Brand Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.
Mail Order Prescription Drugs using Our mail order Prescription Drug vendor – Copayments based on a three (3) month supply	
Generic Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.
Preferred Brand Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.
non-Preferred Brand Drugs	$0 Copayment per Prescription or refill. Deductible does not apply.

Prescription Drugs Purchased Inside of the United States

	Participating Retail Pharmacy	Non Participating Retail Pharmacy
Generic Drugs	$10 Copayment per Prescription or refill. Deductible does not apply.	50% Copayment per Prescription or refill, after Plan Deductible
Preferred Brand Drugs	$50 Copayment per Prescription or refill. Deductible does not apply.	50% Copayment per Prescription or refill, after Plan Deductible
non-Preferred Brand Drugs	$75 Copayment per Prescription or refill. Deductible does not apply.	50% Copayment per Prescription or refill, after Plan Deductible
Mail Order Prescription Drugs using Our mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
	Participating Provider Mail Order Pharmacy	**Non-Participating Mail Order Pharmacy**
Generic Drugs	$30 Copayment per Prescription or refill. Deductible does not apply.	Not Covered
Preferred Brand Drugs	$150 Copayment per Prescription or refill. Deductible does not apply.	Not Covered
non-Preferred Brand Drugs	$225 Copayment per Prescription or refill. Deductible does not apply.	Not Covered

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, PA 19406

II. Title Page (Cover Page)

The Regents of the University of Colorado, a body corporate and state institution of higher education of the State of Colorado

Group Medical Coverage for Expats

Certificate of Coverage Number: 4EL-8758-27

Effective Date: January 1, 2027

Policy Year: January 1, 2027 to December 31, 2027

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

PRESIDENT

SECRETARY

III. Contact Us

Call Us by dialing Our Toll free number at (800) 621-9215

Contact Customer Service by email at customerservice@bcbsglobalsolutions.com

Write Us at the following address:

4 Ever Life Insurance Company
c/o Blue Cross Blue Shield Global Solutions
933 First Avenue
King of Prussia, PA 19406

NOTICE FOR ALL WHO ARE INSURED FOR MEDICAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to medical treatment are the responsibility of You and Your Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Covered Expenses Benefit Description sections of this Certificate for more details.
- You may request a pre-treatment estimate of benefits for the medical services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a Written response from Us to any Written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your Insurance.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Provider and/or medical facility. If the Provider and/or medical facility agree to accept part of the payment directly from Us, You are responsible for prompt payment of the remaining part of the Provider and/or medical facility charge.
- You should consult with the Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Provider the most current, complete and accurate information about Your medical history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Provider.

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V. Eligibility

This section of Your Certificate describes who is eligible for coverage. We will use Our expertise and judgment to reasonably construe the terms of this Certificate as they apply to Your eligibility for benefits.

Participant Eligibility
To be a Participant under this Plan, You must meet all of the following requirements:
1. You are in a Class of eligible Participants; and
2. You have completed the waiting period, if any; and
3. You pay any required contribution.

Waiting Period
For initial Participant group: None

For new Participants: 1st day of the month following eligibility for the Plan as determined by the Employer

Classes of eligible Participants
The following Classes of Participants are eligible for this insurance:
1. All Expatriates Participants
2. All Inpatriate Participants
3. All Third Country Nationals
4. Select Key Local Nationals

"Expatriate" means an eligible Participant who is working or engaged in the conduct of the Group's business outside of the United States for a period of at least 180 days in a consecutive 12 month period that overlaps with the Policy Year.

"Inpatriate" means an eligible Participant who is a citizen of another country other than the United States whose skills, qualifications, job duties, or expertise is of a type that has caused their Employer or sponsor to transfer or assign them to the United States for a specific and temporary purpose or assignment tied to their employment or engagement in the conduct of the Group's business.

"Third Country National" generally means a Participant who works or engaged in the conduct of the Group's business and is located outside their country of citizenship, and outside the Group's country of domicile.

"Key Local National" means a Participant of the Group working or engaged in the conduct of the Group's business and residing within their country of citizenship and who the Group has deemed or designated as essential to the management of that country's operation.

The Participant normally works or is engaged in the Group's business at least 30 hours a week.

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

Effective Date of Participant Insurance
You will become insured on the date You elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date You become eligible.

You will become insured on Your first day of eligibility, following Your election, if You are in Active Service on that date, or if You are not in Active Service on that date due to Your health status.

Late Entrant – Participant
You are a Late Entrant if:
- You elect the insurance more than 31 days after You become eligible; or
- You again elect the insurance after You cancel Your payroll deduction (if required).

If You do not elect coverage upon becoming eligible or within 31 days of becoming eligible You will be considered a Late Entrant for other than a special enrollment period. You must wait until the Group's next open enrollment period to enroll, except as provided below.

Dependent Insurance

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day You become eligible for Yourself; or
- the day You acquire Your first Dependent.

For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for Your Dependents will become effective on the date You elect it by signing an approved payroll deduction form (if required), but no earlier than the day You become eligible for Dependent Insurance. All of Your Dependents as defined will be included.

Your Dependents will be insured only if You are insured.

Late Entrant – Dependent

- You are a Late Entrant for Dependent Insurance if: You elect the insurance more than 31 days after You become eligible for it; or
- You again elect insurance after You cancel Your payroll deduction (if required).

A Dependent spouse or minor Child enrolled within 31 days following a court order of such coverage will not be considered a Late Entrant.

If You do not elect coverage upon becoming eligible for Dependent insurance or within 31 days of becoming eligible for Dependent insurance You will be considered a Late Entrant for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

Exception for Newborns

Any Dependent Child born while You are insured will become insured on the date of their birth for an initial 31 days. To continue coverage beyond the initial 31-day period, You must notify us of the birth and pay any required premium within 31 days of the birth. If You do not elect to insure Your newborn Child within such 31 days, coverage for that Child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. Please see the Newborn Care in the Covered Expenses section of this Certificate.

Eligibility for Coverage for Adopted Children

Any child who is adopted by You while You are insured will become insured for an initial 31 days from either the date of placement of the child in Your home for the purpose of adoption or the date You become a party in a suit to adopt such child, whichever is earlier. To continue coverage beyond 31 days, You must enroll the adopted child within 31 days from either the date of placement or the date You become a party in a suit to adopt. If You do not enroll the child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

Special Enrollment Period

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

A special enrollment period applies to You and/or Your Dependents when one of the following events occurs:

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

A special enrollment period also applies for You and/or Your Dependent who did not enroll during Your initial enrollment period if the following are true:

- You previously declined coverage under the Policy, but You and/or Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if We receive the completed enrollment application and any required premium within 60 days of the date of determination of subsidy eligibility.
- A court or administrative order has order coverage to be provided.
- You and/or Your Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during Your initial enrollment period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including divorce or death) as well as a Child of a Participant who has lost coverage under Chapter 62 Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §1396, et seq., Grants to States for Medical Assistance Programs) other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396, Program for Distribution of Pediatric Vaccines).
  - Termination of employment or reduction in hours of employment.

- The Employer stopped paying the contributions. This is true even if You and/or Your Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the Employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The plan no longer offers benefits to a class of individuals that include the eligible Participant and/or Dependent.
- You and/or Your Dependent incurs a claim that would exceed a lifetime limit on all benefits.
- You and/or Your Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP).

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if We receive the completed enrollment form and any required premium within 31 days of the event unless otherwise noted above.

VI. How to Access Your Services and Obtain Approval of Benefits

You will find terms starting with capital letters throughout Your Certificate of Coverage ("Certificate"). To help You understand Your benefits, most of these terms are defined in the Definitions section of Your Certificate.

This Certificate, and any attached Riders, is issued by 4 Ever Life Insurance Company ("Insurer") through a Policy issued to the HTH Group Insurance Trust (the "Group"). The Insurer will use a third party Administrator to perform certain of its duties on its behalf. The Group and the Participant are hereby notified of the use of Worldwide Insurance Services, LLC d/b/a Blue Cross Blue Shield Global Solutions℠ (BCBS Global Solutions℠) its Administrator.

4 Ever Life Insurance Company and BCBS Global Solutions are Independent Licensees of the Blue Cross Blue Shield Association.

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

This Plan's benefits and Your Out-of-Pocket Expenses depend on the Providers You see. In this section You will find out how the Providers You see can affect this Plan's benefits and Your costs.

This Plan makes available to You sufficient numbers and types of Providers to give You access to all covered services. Our Provider Networks include Hospitals, Physicians, and a variety of other types of Providers.

This Plan does not require use or selection of a Primary Care Physician or require referrals for specialty care. Covered Persons may self-refer to Providers, including obstetricians, gynecologists, and pediatricians, to receive care, and may do so without prior authorization.

Coverage Area

Benefits under this insurance are available in the following locations:

- Any country outside of the United States, including the eligible Participant's Home Country.
- Inside the United States

Note: whenever coverage provided under this Plan would be in violation of any U.S. economic or trade sanctions, such coverage shall be null and void.

BlueCard® Program and Other Inter-Plan Arrangements

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

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

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

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

- **BlueCard® Program.** Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating healthcare Providers.

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

  - The billed covered Charges for Your covered services; or

- The negotiated price that the Host Blue makes available to Us.

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

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

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

- **Non-Participating Health Care Providers.**
  Your Liability Calculation. When covered Health Care Services are provided by Non-Participating health care Providers, the amount You pay for such services will generally be based on the Allowed Amount. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  Exceptions. In certain situations, We may use other payment bases, such as billed covered Charges, the payment We would make if the Health Care Services had been obtained within Our Network, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by Non-Participating health care Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  If a Covered Person incurs Charges for services or supplies that are not reasonably available through a U.S. Participating Provider, Non-Participating Health Care Providers will be reimbursed for these Charges at the same percentage level of reimbursement as a U.S. Participating Provider. We will pay the claim, at a minimum, at the usual and customary rate for the service. This exception shall not apply solely because a Covered Person chooses to receive services from Providers other than Participating Providers for the Covered Person's own convenience.

  We will credit any Out-of-Pocket amounts shown by the Covered Person to have been actually paid to the Non-Participating Health Care Provider for covered services that were above and beyond the Allowed Amount toward the Covered Person's Deductible and annual Out-of-Pocket maximum applicable to in-Network services, provided these amounts would have been credited had the Provider been a U.S. Participating Provider.

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

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

Network Adequacy
You have the right to an adequate Network of preferred Providers (also known as "Blue Choice PPO Network").

You have the right, in most cases, to obtain estimates in advance:
- from out-of-Network Providers of what they will charge for their services; and
- from Your Insurer of what it will pay for the services.

You may obtain a current directory of preferred Providers at the following website:www.bcbsglobalsolutions.com or by calling Customer Service at the number listed on the back of our identification card or by email customerservice@bcbsglobalsolutions.com for assistance in finding available preferred Providers.

If You are treated by a Provider or facility that is not a preferred Provider, You may be billed for anything not paid by the Insurer.

If the amount You owe to an out-of-Network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than $500 (not including Your Copayment, Coinsurance, and Deductible responsibilities) for services received in a Network hospital, You may be entitled to have the parties participate in a teleconference.

If directory information is materially inaccurate and You rely on it, You may be entitled to have an out-of-Network claim paid at the in-Network percentage level of reimbursement and Your Out-of-Pocket expenses counted toward Your in-Network Deductible and Out-of-Pocket maximum.

Continuity of Care
If a Covered Person is receiving treatment, services or supplies from a Network Provider and that Network Provider is terminated from the Network, benefits for such services, treatment or supplies will continue to be paid at the Network Provider rate for a period of 90 days from the date of the Network Provider's termination if the treatment, services or supplies are being provided for Special Circumstances such as:

- Disability;
- An acute condition;
- A "Life-threatening" Sickness; or
- Being past the 24th week of pregnancy and receiving treatment in accordance with the dictates of medical prudence. If a Covered Person is past the 24th week of pregnancy at the time of termination, benefits will continue to be paid at the Network Provider rate through delivery of the child and for immediate postpartum care and the follow-up checkup within the six-week period after delivery.

If a Covered Person has been diagnosed as having a Terminal Illness at the time of termination, services, treatment or supplies will continue to be paid at the Network Provider rate for the nine-month period after the effective date of the termination of the Network Provider.

As used in this provision "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.

Special Circumstances mean a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by that treating Physician or Provider could cause harm to the Covered Person. Special Circumstances shall be identified by the treating Physician or health care Provider who must request that the Covered Person be permitted to continue treatment under the Physician or Provider's care and agree not to seek payment from the Covered Person of any amounts for which the Covered Person would not be responsible if the Physician or health care Provider were still part of the Network.

International/Foreign Country Providers

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, Covered Expenses for these Foreign Country Providers are based on the Allowed Amount, if applicable, which may be less than actual billed Charges. Foreign Country Providers can bill the Covered Person for amounts exceeding Covered Expenses. BCBS Global Solutions provides a list to Covered Persons of Foreign Country Providers with whom BCBS Global Solutions has contracted to accept assignment of claims and direct payments from the Insurer or its Administrator for Covered Expenses incurred by Covered Persons, thus alleviating the necessity of the Covered Person paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are not Participating Providers, but rather a group of Foreign Country Providers for whom BCBS Global Solutions is able to provide background information and to arrange access for Covered Persons.

How To File Your Claim

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

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

CLAIM REMINDERS

- Be sure to use Your Insurance ID when Your file a claim or when You call the customer service center.
- Your Insurance ID is shown on Your identification card.
- Be sure to follow the instructions listed on the claim form carefully when submitting a claim to the Administrator.

Timely Filing of U.S. Non-Participating Providers & International Claims
4 Ever Life Insurance Company and its Administrator will consider claims for coverage under the Policy when proof of loss (a claim) is submitted within 365 days from the date the proof of loss is otherwise required to be provided for U.S. Non-Participating Providers and International benefits. If claims are not submitted within 365 days for U.S. Non-Participating Providers and International benefits, the claim will not be considered valid and will be denied.

If notice of claim or Proof of loss is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or Proof are given as soon as is reasonably possible.

If any time limitation provided in the Group Policy regarding claims is less than that permitted by the law of the jurisdiction in which the claimant resides at the time the Group Policy is issued, the time limitation of the prevailing jurisdiction shall apply.

VII. Benefits/Coverage (What is Covered)

This section of Your Certificate describes the specific benefits available for covered services. Benefits, subject to the Copayments, Coinsurance, Deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered Sickness, disease or Injury;
- It must be Medically Necessary (please see the "Definitions" section in this Certificate) and must be furnished in a Medically Necessary setting. Inpatient care is only covered when You require care that could not be provided in an Outpatient setting without adversely affecting Your condition or the quality of care You would receive;
- It must not be excluded from coverage under this Plan;
- The expense for it must be incurred while You are covered under this Plan and after any applicable waiting period required under this Plan is satisfied;
- It must be furnished by a Provider (please see the "Definitions" section in this Certificate) who is performing services within the scope of their license or certification;
- It must meet the standards set in Our medical and payment policies. Our medical and payment policies are used to administer the terms of the Plan. Medical policies are generally used to determine if a Covered Person has coverage for a specific procedure or service. Payment policies define billing and Provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA).

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

Preventive Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider inside the United States and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").

However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply.

You may contact Us at the number on Your ID card or visit Our website www.bcbsglobalsolutions.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

Well-Baby and Well-Child Care. We cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also covered. This benefit is provided to Covered Persons from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider inside the United States.

In addition, charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Department of Health and Human Services.

Adult Annual Physical Examinations. We cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, cholesterol screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the covered preventive Services is available on Our website at www.bcbsglobalsolutions.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Policy Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider inside the United States.

Adult Immunizations. We cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider inside the United States.

Well-Woman Examinations. We cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.bcbsglobalsolutions.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider inside the United States.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Covered Persons age 35 through 39;
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Covered Persons ages 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Covered Persons age 40 and over.

If a Covered Person of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We cover mammograms as recommended by the Covered Person's Provider. However, in no event will more than one (1) preventive screening per Policy Year be covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs, are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider inside the United States.

Note: should the USPSTF revise the recommendations, this benefit will be modified to conform with those recommendations.

Family Planning and Reproductive Health Services. We cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise covered under the Prescription Drug Coverage section of this Certificate, patient education and counseling on use of contraceptives and related topics, follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider inside the United States.

We also cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not cover services related to the reversal of elective sterilizations.

Bone Mineral Density Measurements or Testing. We cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider inside the United States and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

Screening for Prostate Cancer. We cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

Note: should the USPSTF revise the recommendations, this benefit will be modified to conform with those recommendations.

Colon Cancer Screening. We cover colon cancer screening for Covered Persons ages 45 through 75, including all colon cancer examinations and laboratory tests in accordance with the USPSTF for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

Note: should the USPSTF revise the recommendations, this benefit will be modified to conform with those recommendations.

Early Detection of Cardiovascular Diseases. Benefits for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years, performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcification; or
- Ultrasonography measuring carotid intima-media thickness and plaque.
- Coverage is limited to a Covered Person who is:
- A male between 46 and 75 years of age; or
- A female between 56 and 75; 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.

  This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider inside the United States.

Travel Immunizations. Charges made for or in connection with travel immunization for Covered Persons as stated in the Schedule of Benefits.

Emergency Services, Urgent Care and Ambulance Services

Emergency Services

We cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or their unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. However, We will cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or Stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are covered in an emergency department**.

   We do not cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We cover Inpatient Hospital services following Emergency Department Care at a non-Participating Hospital at the In-Network Cost-Sharing. If Your medical condition permits Your transfer to a Participating Hospital, We will notify You and work with You to arrange the transfer.

3. **Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services. We will pay a Non-Participating Provider the Allowed Amount.

   If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the services.

   You are responsible for any Cost-Sharing as stated in the Schedule of Benefits. You will be held harmless for any Non-Participating Provider charges that exceed Your In-Network Cost-Sharing. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us.

Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

Ambulance Transportation

Pre-Hospital Emergency Medical Services. We cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. We will, however, only cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or their unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible, or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider at the Allowed Amount.

Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

Non-Emergency Ambulance Transportation

We cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective acute care Facility; or
- From an acute care Facility to a sub-acute setting.

Limitations/Terms of Coverage

- We do not cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not cover non-ambulance transportation such as ambulette, van or taxi cab or ride share.

- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Payments for Air Ambulance Services
We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider Allowed Amount. However, the Allowed Amount will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing for air ambulance services as shown in the Schedule of Benefits. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us.

Inpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Hospital Services.

We cover Inpatient Hospital services for acute care or treatment given or ordered by a health care professional for an illness, injury or disease of a severity that must be treated on an Inpatient basis, including:

- Semiprivate room and board;

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

- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.
- Parental Accommodation – if charged by a Hospital, Charges for one parent or legal guardian to stay in a Hospital with a covered child under the age of 18.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an Inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

Observation Services.

We cover observation services in a Hospital. Observation services are Hospital Outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services.

We cover medical visits by a health care professional on any day of Inpatient care covered under this Certificate.

Inpatient Stay for Maternity Care.
We cover Inpatient maternity care in a Hospital for the mother, and Inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, We will cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later.

We also cover the Inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a health care professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

Inpatient Stay for Mastectomy Care.
We cover Inpatient services for Covered Persons undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

Autologous Blood Banking Services.
We cover autologous blood banking services only when they are being provided in connection with a scheduled, covered Inpatient procedure for the treatment of a disease or injury. In such instances, We cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

Habilitation Services.
We cover Inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy. Any limitations are shown in the Schedule of Benefits. The visit limit applies to all therapies combined.

Rehabilitation Services.
We cover Inpatient Rehabilitation Services consisting of physical therapy, massage therapy, speech therapy and occupational therapy. Any limitations are shown in the Schedule of Benefits. The visit limit applies to all therapies combined.

We cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date Outpatient surgical care is rendered.

Skilled Nursing Facility.
We cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in “Hospital Services” above. Custodial, convalescent or domiciliary care is not covered (see the Exclusions and Limitations section of this Certificate. An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. Any limitations are shown in the Schedule of Benefits.

Limitations/Terms of Coverage for Inpatient Care
1. When You are receiving Inpatient care in a Facility, We will not Cover additional charges for special duty Nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility’s maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.

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

2. We do not cover radio, telephone or television expenses, or beauty or barber services.

3. We do not cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive Inpatient care unless Our denial is overturned by an External Appeal Agent.

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

Preventive Care and Access to Coverage

We cover the following services for behavioral, mental health and substance use disorder treatment without Deductibles, Copayments or Coinsurance:

- An unhealthy alcohol use screening for adults;
- A preventive screening for depression in adolescents and adults; and
- Perinatal maternal counseling for persons at risk.:

Mental Health Care Services.

We cover the following mental Health Care Services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We cover Inpatient mental Health Care Services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for Inpatient services for mental health care is limited to:
   - A psychiatric center or Inpatient Facility under local jurisdiction;
   - A state or local government run psychiatric Inpatient Facility;
   - A part of a Hospital providing Inpatient mental Health Care Services under an operating certificate issued by the state or jurisdiction it is operating in;
   - A comprehensive psychiatric emergency program or other Facility providing Inpatient mental health care that has been licensed in the state that is operating. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations, or a national or international accreditation organization recognized by Us.

   We also cover Inpatient mental Health Care Services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. A person is considered confined in a Mental Health Residential Treatment Center when they are a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician. Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

   Coverage for residential treatment services is limited to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations, or a national or international accreditation organization recognized by Us.

2. **Outpatient Services.** We cover outpatient mental Health Care Services, including but not limited to Partial Hospitalization program services and intensive Outpatient program services, relating to the diagnosis and treatment of mental health conditions. Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period. Coverage for residential treatment services is limited to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations, or a national or international accreditation organization recognized by Us.

   Outpatient services also include nutritional counseling to treat a mental health condition.

3. **Psycho-Educational Testing.** Psycho-educational testing conducted by a licensed clinical, educational, or counseling Psychologist in order to assess and diagnose functional limitations due to learning disabilities, including, but not limited to, attention deficit hyperactivity disorder (ADHD). This benefit covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with the student to review test results and recommendations for appropriate academic accommodation are also covered under this benefit.

4. **Autism Spectrum Disorder.** We cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed Psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, or treatment of Autism Spectrum Disorder. For purposes of this benefit, "Autism Spectrum Disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

   a. **Screening and Diagnosis.** We cover assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.

b. **Assistive Communication Devices.** We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed Psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We do not cover items, such as, but not limited to, laptop, desktop or tablet computers. We cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

c. **Behavioral Health Treatment.** We cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed Provider. We cover applied behavior analysis when provided by a licensed or certified applied behavior analysis health care professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

d. **Psychiatric and Psychological Care.** We cover direct or consultative services provided by a psychiatrist, Psychologist or a licensed clinical social worker, licensed in the state in which they are practicing.

e. **Therapeutic Care.** We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat Autism Spectrum Disorder and when the services provided by such Providers are otherwise covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

f. **Pharmacy Care.** We cover Prescription Drugs to treat Autism Spectrum Disorder that are prescribed by a Provider legally authorized to prescribe. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

Substance Use Services.

We cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We cover Inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities which are licensed, certified or otherwise authorized by a state agency and accredited by the Joint Commission or a national or international accreditation organization recognized by Us, as alcoholism, substance abuse or chemical dependence treatment programs.

   We also cover Inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by a state agency and accredited by the Joint Commission or a national or International accreditation organization recognized by Us, as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We cover Outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to Partial Hospitalization program services, intensive Outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such coverage is limited to Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for Outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

   Additional Family Counseling. We also cover up to 20 Outpatient visits per Policy Year for family counseling. A family member will be deemed to be covered, for the purpose of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

In addition to all other exclusions listed in the Exclusions and Limitations, the exclusions listed directly below apply to services described under Mental Health Care and Substance Use Services

- Services performed in connection with conditions not classified in the current edition of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature; for borderline intellectual functioning; occupational problems; counseling related to consciousness raising; and for vocational or religious counseling.
- I.Q. testing.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- Art therapy, music therapy, dance therapy, horseback therapy, adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
- Any costs associated with voluntary support groups, such as Alanon or Alcoholics Anonymous.
- Custodial Care, including but not limited to geriatric day care, halfway houses, quaterway houses, recovery houses, and other sober living residences.
- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Transitional Living services.

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Acupuncture or Acupressure.

We cover acupuncture or Acupressure services when Medically Necessary to relieve pain, induce surgical anesthesia, or to treat a covered Sickness, Injury, or condition rendered by a health care professional licensed to provide such services. Acupuncture or Acupressure means to remedy illness through either the application of deep finger pressure or needles at points located along an invisible system of energy channels called meridians. Any limitations are shown in the Schedule of Benefits.

Acquired Brain Injury.

Benefits for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including Outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, the Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Note: Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Treatment for an Acquired Brain injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Advanced Imaging Services.

We cover PET scans, MRI, nuclear medicine, and CAT scans.

Allergy Testing and Treatment.
We cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

Ambulatory Surgical Center Services.
We cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

Chemotherapy and Immunotherapy.
We cover chemotherapy and immunotherapy in an Outpatient Facility or in a health care professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally administered anti-cancer drugs are covered under the Prescription Drug Coverage section of this Certificate.

Chiropractic Services.
We cover Chiropractic Care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this Certificate. Any limitations are shown in the Schedule of Benefits.

The following limitation applies to Chiropractic Care:
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

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

Chronic Care.
Complex chronic care management first 60 mins (CPT 99487) and each additional 30 mins (CPT 99489) per calendar month and Chronic care management services (CPT 99490), at least 20 mins per calendar month.

Cleft Lip/Cleft Palate
Coverage shall be provided for the condition or Sickness related to or developed as a result of cleft lip or cleft palate. Such coverage shall also include benefits to the extent Medically Necessary to include but not be limited to the following:
- Oral and facial surgery, surgical management, and follow-up care;
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
- Orthodontic treatment and management;
- Prosthodontic treatment;
- Habilitative Speech Therapy
- Audiological assessments and treatment; and
- Otolaryngology treatment and management.

Clinical Trials.
We cover the Routine Patient Care Costs arising from a Clinical Trial for a qualified individual. You must meet the eligibility criteria laid out in the Clinical Trial's protocol or action plan and the attending health care professional must conclude that participation in the Clinical Trial is appropriate.

The Clinical Trial must meet the following requirements:

- The subject or purpose of the trial must be the evaluation of an item or service that falls within the Covered Medical Services of this Group Policy and is not specifically excluded from coverage;
- The trial must not be designed exclusively to test toxicity or disease pathophysiology;
- The trial must have therapeutic intent;
- Trials of therapeutic interventions must enroll patients with diagnosed disease;
- The principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes;
- The trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;
- The trial does not unjustifiably duplicate existing studies; and
- The trial is in compliance with federal regulations relating to the protection of human subjects.

"Routine Patient Care Costs" include items and services that are otherwise generally available to a qualified individual that are provided in the Clinical Trial except:

- the investigational items or service itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients; and
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

"Clinical Trials" only include trials that are approved or funded by use of the following entities:

- One of the National Institutes of Health (NIH);
- An NIH Cooperative Group or center which is a formal network of facilities that collaborate or research projects and have an established NIH-approval peer review program operating within the group. This includes, but is not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- The federal Departments of Veterans' Affairs or Defense;
- An institutional review board of an institution that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH; or
- A qualified research entity that meets the criteria for NIH Center Support grant eligibility.

We do not cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

Developmental Delays in Children.

In addition to rehabilitative and habilitative therapies otherwise covered under this Policy, benefits are provided for rehabilitative and habilitative therapies to a child who is a Covered Person and developmentally delayed when such therapies are:

- Medically Necessary; and
- Provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

Rehabilitative and habilitative therapies include:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

Dialysis.

We cover dialysis treatments of an acute or chronic kidney ailment.

We also cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- Benefits for services of a Non-Participating Provider are covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

Gender Reassignment Surgery (GRS)

Gender reassignment surgery (GRS), either as a male-to-female (MTF) transition or as a female-to-male (FTM) transition, consists of medical and surgical treatments that change primary sex characteristics for individuals with gender dysphoria or gender identity disorder who wish to make a permanent transition.

Gender Identity is defined as an individual's gender appearance, expression or behavior regardless of the individual's assigned sex at birth. Determinations of Medical Necessity, eligibility and prior authorization requirements for diagnoses related to an insured's gender identity must be based on current medical standards established by nationally recognized transgender health medical experts.

GRS may be considered Medically Necessary when ALL of the following are met:

- The individual is greater than or equal to 18 years of age; **and**
- The individual has the capacity to make a fully informed decision and to consent for treatment; **and**
- The individual has been diagnosed with the gender dysphoria, including **ALL** of the following:
  - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make their body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**

- The individual's transgender identity has been present persistently for at least two (2) years; **and**
- The dysphoria is not a symptom of another mental disorder or a chromosomal abnormality; **and**
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The individual is an active participant in a recognized gender identity treatment program and demonstrates **ALL** of the following conditions:
  - The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender; **and**
  - For breast surgery
    - Initiation of hormonal therapy (unless medically contraindicated or individual is unable or unwilling to take hormones); **and**
    - One referral from a qualified mental health professional with written documentation submitted to the Physician performing the breast surgery**; and**
  - For genital surgery
    - Documentation of at least 12 months of continuous hormonal sex reassignment therapy, unless medically contraindicated or individual is unable or unwilling to take hormones) (may be simultaneous with real life experience); **and**
    - Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent; **and**
  - Separate evaluation by the Physician performing the genital surgery.

When **ALL** of the above criteria are met, the following breast/genital surgeries may be considered Medically Necessary for the following indications:

MTF:
- Breast augmentation
- Orchiectomy
- Clitoroplasty
- Colovaginoplasty
- Labiaplasty
- Orchiectomy
- Penectomy
- Vaginoplasty

Note: Although not a requirement, it is recommended that MTF undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

FTM:
- Breast reconstruction (e.g., mastectomy)
- Colpectomy/Vaginectomy
- Hysterectomy
- Metoidioplasty
- Penile prosthesis
- Phalloplasty
- Reduction mammoplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular prosthesis implantation
- Urethroplasty

Note: Penile prosthesis surgery is typically performed at stage two (2) or three (3) of a multi-stage phalloplasty (a minimum of nine (9) months following stage one (1)).

The following procedures that may be performed as a component of a gender reassignment are considered cosmetic and, therefore, non-covered (this is not an all-inclusive list):
- Blepharoplasty
- Blepharoptosis
- Chin augmentation
- Collagen injections
- Cricothyroid approximation
- Facial bone reduction-facial feminizing
- Hair removal – electrolysis or laser hair removal
- Hair transplantation
- Laryngoplasty
- Lip reduction/enhancement
- Liposuction

- Mastopexy
- Nipple/areola reconstruction
- Removal of redundant skin
- Rhinoplasty
- Rhytidectomy
- Trachea shave/reduction thyroid chondroplasty

Home Health Care.

We cover care provided in Your home by a home health agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional Nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the home health agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the home health agency to the extent such items would have been covered during a hospitalization or confinement in a Skilled Nursing Facility.

Any limitations are shown in the Schedule of Benefits. Each visit by a member of the home health agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services or Habilitation Services benefits.

Home Health Care Limits

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

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

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

Infertility Treatment.

We cover services for the diagnosis and treatment (surgical and medical) of Infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Covered Person's medical history or physical findings.

Such coverage is available as follows:

1. **Basic Infertility Services.** Basic Infertility services will be provided to a Covered Person who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine.

   Basic Infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysteroscopy, Hysterosalpingogram or Sono-hystrogram;
   - Laparoscopy and Laparotomy Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the Basic Infertility services do not result in increased fertility, We cover comprehensive Infertility services. Comprehensive Infertility services include:
   - Artificial insemination

3. **Advanced Infertility Services.** We cover the following advanced Infertility services:
   - Up to six (6) cycles per lifetime of in vitro fertilization;
   - Up to six (6) cycles per lifetime of gamete intrafallopian tube transfers or zygote intrafallopian tube transfers. Coverage for gamete intrafallopian tube transfers or zygote intrafallopian tube transfers does not count towards the in vitro fertilization benefit limit;
   - Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic Infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic Infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Please note: Elective cryopreservation for the delay of childbearing is NOT covered.

5. **Exclusions and Limitations.** We do not cover:
   - Cryopreservation of immature eggs;
   - Reversal of voluntary sterilization (tuboplasty or vasoplasty);
   - Reversal of vasectomies;
   - Testicular tissue or testis xenografting;
   - Any treatment for infertility in absence of an associated diagnosis;
   - Services when either of the partners has had a previous sterilization procedure, with or without surgical reversal and in females who have undergone a hysterectomy. Individuals who have undergone gender reassignment surgery are considered to have undergone elective sterilization and are therefore not considered eligible.
   - experimental and investigational Infertility services including, but not limited to:
     - immunological testing including, but not limited to, Antiphospholipid, embryotoxicity assays, reproductive immunophenotype (RIP), circulating natural killer cell measurement, Th1 and Th2 intracellular cytokine assay or antiprothrombin antibodies;
     - uterine and endometrial receptivity testing including, but not limited to, Endometrial function tests, E-tegrity, Beta-3 integrin test etc.);
     - sperm DNA integrity testing including, but not limited to, Sperm Chromatin structure assay, TUNEL assay, Comet assay, human sperm activation assay, sperm DNA fragmentation assays or sperm DNA decondensation;
     - ovarian reserve testing including, but not limited to, Serum inhibitin B measurement or anti-mullerian hormone testing;
     - hemizona test;
     - computer assisted sperm motion analysis;
     - reactive oxygen species testing (ROS);
     - in vitro testing of sperm penetration;
     - DHEA and FSH manipulation;
     - hyaluronan binding assay;
     - manual soft tissue therapy for the treatment of pelvic adhesions including, but not limited to, WURN technique or clear passage therapy;
     - immune treatments including, but not limited to, preimplantation glucocorticoids, anti-tumor necrosis factor agents, leucocyte immunizations or IV immunoglobulins;
     - direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion;
     - laser assisted necrotic blastomere removal from cryopreserved embryos; or
     - HCG, hMG, urofollitropin and recombinant follitropins, Follistim and Follistim AQ for idiopathic male infertility (i.e. for those without documented hypogonadotropic hypogonadism, idiopathic microphallus and all other indications in males).
   - Commercially available over-the-counter home ovulation prediction tests or pregnancy kits;
   - Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;
   - Cloning; or
   - Medical and surgical procedures that are Experimental /Investigational, unless Our denial is overturned by an External Appeal Agent.

Infusion Therapy.

We cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized health care professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

Any visits for home infusion therapy count toward Your home health care visit limit.

Interruption of Pregnancy.
We cover Medically Necessary abortions including abortions in cases of rape, incest or fetal malformation where legally allowed. We cover elective abortions where legally allowed for one (1) procedure per Covered Person, per Policy Year.

Laboratory Procedures, Diagnostic Testing and Radiology Services.
We cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

Maternity and Newborn Care.
We cover services for maternity care provided by a Physician or midwife, Nurse practitioner, Hospital or birthing center. We cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed in the state or jurisdiction where the services are rendered. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of Inpatient maternity care.

We cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding.

Coverage for a Doula (a trained birth assistant) services in home or facility (pre and post-natal combined). See Schedule of Benefits for any limitations.

- Follow-up care consistent with accepted medical practice that is ordered by the attending Provider, in consultation with the mother. Follow-up care includes services of the attending Provider, a home health agency and/or a registered Nurse.
- Circumcision

Inpatient Professional Care
Benefits for these services are subject to Your Certificate year Deductible and coinsurance when services are provided by an attending Provider.

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

When You see a Provider outside an office setting, benefits are subject to Your Certificate year Deductible and coinsurance.

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

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

Nutritional Counseling.
Services are provided for the assessment and guidance of Covered Persons at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness. Nutritional counseling is indicated for certain diagnoses, including diabetes, malnutrition, eating disorders and cardiovascular disease.

Nutritional counseling benefits are not provided for weight loss in the absence of co-morbid conditions, or for conditions that have not been shown to be nutritionally related, including, but not limited to, chronic fatigue syndrome and hyperactivity.

Limitations are shown in the Schedule of Benefits.

Nutritional Formulas.
Nutritional formulas, low protein modified food products, or other medical food consumed or administered enterally (via tube or orally) which are Medically Necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician. Coverage is also provided for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins (ii) severe food protein-induced enterocolitis syndrome (iii) eosinophilic disorders, as evidenced by the results of a biopsy; and (iv) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract, provided the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.

Obesity Treatment.
Covered Expenses include charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of obesity for the following Outpatient weight management services:
- An initial medical history and physical exam; or
- Diagnostic tests given or ordered during the first exam

Surgical treatment of Morbid Obesity is covered when certain conditions are met. If You are Morbidly Obese, we cover the following surgical procedures:

- gastric bypass;
- gastric stapling;
- biliopancreatic bypass with duodenal switch;
- gastric banding; and
- sleeve gastrectomy.

You must:

- have achieved full growth and be 18 years or older (Covered Persons under age 18 may also qualify under certain circumstances);
- have no specific, treatable, correctable cause for the Morbid Obesity (e.g., endocrine disorder);
- complete a structured diet program in the 2-year period that immediately precedes the request for the surgery;
- have received a psychological evaluation specifically for the diagnosis of obesity or Morbid Obesity;
- have received appropriate medical clearances for the surgery; and
- meet the definition of Morbid Obesity

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

The Plan does not cover:

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

Outpatient Hospital Services.

We cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an Outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

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. Physician Hospital Visits will be considered to have Prior Approval from the Company if the Physician visit is related to a diagnosis for which an Inpatient stay has received Prior Approval from the Company.

Preadmission Testing.

We cover preadmission testing ordered by Your Physician and performed in Hospital Outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

PrEP Baseline and Monitoring Services

We cover PrEP baseline and monitoring services, consistent with USPSTF recommendations, without copayment or cost sharing for services obtained from Participating Providers when HIV PrEP medication is prescribed. Baseline and monitoring services include:

- HIV testing; Hepatitis B and C testing; creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR); pregnancy testing; sexually transmitted infection screening and counseling; and adherence counseling.
- Office visits associated with baseline and monitoring services are covered without cost sharing, when the service is not billed separately from an office visit, and the primary purpose of the office visit is the delivery of the recommended preventive service.

Prescription Drugs for Use in the Office and Outpatient Facilities.

We cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be covered under the Prescription Drug Coverage section of this Certificate. Certain Prescription Drugs may have to be Precertified.

Primary Care Physician Office Visits.

Coverage is provided for services provided by a Primary Care Physician or an advanced practice Nurse or Physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. The Covered Person is responsible for any Copayment, Deductible, and Coinsurance specified in the Schedule of Benefits.

Services covered, but are not limited to, office visits, diagnostic x-rays, lab, surgery by the Primary Care Physician, accident or Emergency Care, allergy shots and injections. Office visits may include house calls.

Private Duty Nursing

Private duty nursing services must be preauthorized. Any limitations are shown in the Schedule of Benefits.

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

   The Plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:
   - A change in Your medication;
   - Treatment of an urgent or Emergency Medical Condition by a Physician;
   - The onset of symptoms indicating a need for emergency treatment;
   - Surgery;
   - An Inpatient Hospital stay.

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

Retail Health Clinics.

We cover basic Health Care Services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a Physician's assistant or Nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses.

Rehabilitation Services.

We cover Rehabilitation Services consisting of physical therapy, massage therapy, speech therapy and occupational therapy in the Outpatient department of a Facility or in a health care professional's office. Limitations are shown in the Schedule of Benefits and the visit limit applies to all therapies combined.

We cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date Outpatient surgical care is rendered.

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

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

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

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

Second Opinions.

1. **Second Cancer Opinion.** We cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-Network basis.

2. **Second Surgical Opinion.** We cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
   - The second opinion must be given by a board-certified Specialist who personally examines You.
   - If the first and second opinions do not agree, You may obtain a third opinion.
   - The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will approve Covered Services supported by a majority of the Providers reviewing Your case.

Surgical Services.

We cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a Sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an Inpatient and Outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a Nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant. For an assistant surgeon and or a co-surgeon, the maximum amount payable will be limited to Our or Our Administrator's reimbursement policies.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

2. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest Allowed Amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

Oral Surgery.

We cover the following limited dental and oral surgical procedures:

- Charges made by a Physician, a Dentist and Hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to Accidental Injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 6 months of the injury.
- Any dental surgery or other dental service performed in a Hospital (Inpatient or Outpatient) or an ambulatory surgical facility, provided the Covered Person has a condition (e.g., diabetes, heart condition, etc.) that makes the provision of those services in that setting Medically Necessary

- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders (TMJ). TMJ appliances are not covered under the Medical Plan. Medical and dental services and supplies must meet all of the following requirements:
  - Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
  - Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
  - Recognized as effective, according to the professional standards of good medical or dental practice.
  - Not Experimental / Investigational, as determined by Us according to the criteria stated under "Definitions," or primarily for cosmetic purposes.
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct provided:
  - The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.
- Hospital services and supplies received for a stay required because of Your condition.
- General anesthesia and related facility services for dental procedures are covered when Medically Necessary for the following reasons:
  - Covered Persons who are under 7 years of age;
  - Covered Persons who are developmentally disabled, regardless of age; or
  - Covered Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.
  - Covered Persons who are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by the Other Health Provider providing the dental care.

Reconstructive Breast Surgery.

We cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also cover implanted breast prostheses following a mastectomy or partial mastectomy.

Other Reconstructive and Corrective Surgery.

We cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Specialty Care Physician Office Visits.

Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of the specialty care Physician. Office visits may include house calls. The Covered Person is responsible for any Copayment, Deductible, and Coinsurance specified in the Schedule of Benefits.

Telehealth Service and Telemedicine Medical Services

This Plan provides benefits for covered services that are appropriately provided through Telehealth Service and Telemedicine Medical Service, subject to the terms and conditions of the Plan and it will be covered at the same rate as an in person visit. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

Equipment costs and transmission costs associated with Telehealth Service and Telemedicine Medical Services are not reimbursable.

Transplantation Services.
Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Expense and is not an Experimental / Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:
- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Expenses and are payable through the organ recipient's coverage under the Policy, limited to donor:
- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on Your ID card for information about our specific guidelines regarding Benefits for transplant services.

Additional Benefits, Equipment and Devices
Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Diabetic Equipment, Supplies and Self-Management Education.
We cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed health care professional legally authorized to prescribe.

1. **Equipment and Supplies.**
   We cover the following equipment and Related Supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe including but not limited to:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump

- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be Medically Necessary and appropriate by a treating Physician or other practitioner through a written order.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe to the following non-Physician, medical educators: certified diabetes Nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We cover only basic models of glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Durable Medical Equipment and Braces.

We cover the rental or purchase of Durable Medical Equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We cover the cost of repair or replacement when made necessary by normal wear and tear. We do not cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Limitations

We do not cover equipment designed for Your comfort or convenience as it does not meet the definition of Durable Medical Equipment. Examples included, but are not limited to:

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

2. Braces.
We cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We cover replacements when growth or a change in Your medical condition make replacement necessary. We do not cover the cost of repair or replacement that is the result of misuse or abuse by You.

Hearing Aids.

1. External Hearing Aids.
We cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears. Limitations are shown in the Schedule of Benefits.

2. Pediatric Hearing Aids and Cochlear Implants
Charges made for or in connection with Medically Necessary hearing aid or cochlear implant and related services and supplies for a Covered Person who is 18 years of age or younger. Coverage includes:

- Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- Any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for education gain; and
- For a cochlear implant, an external speech processer and controller with necessary components limited to:
  - One cochlear implant in each ear as medically or audiologically necessary;
  - Replacement every three (3) years as medically or audiologically necessary.

Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We cover Inpatient Hospice Care in a Hospital or hospice and home care and Outpatient services provided by the hospice, including drugs and medical supplies. We also cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We cover Hospice Care only when provided as part of a Hospice Care Program certified by the state or jurisdiction in which the hospice is located. We do not cover:

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

- for the services of a person who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house;
- for any period when You or Your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Policy;
- for services or supplies that are primarily to aid You or Your Dependent in daily living.

Medical Supplies.

We cover medical supplies that are required for the treatment of a disease or injury which is covered under this Certificate. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply coverage.

Prosthetics.

1. External Prosthetic Devices.
We cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We cover wigs, up to one wig or hairpiece every two years, only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not cover dentures or other devices used in connection with the teeth unless required due to an Accidental Injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not covered under this section of the Certificate.

We do not cover shoe inserts.

We cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We cover the cost of one (1) prosthetic device, per limb, per lifetime. We also cover the cost of repair and replacement of the prosthetic device and its parts. We do not cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. **Internal Prosthetic Devices.**
   We cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

   Coverage also includes repair and replacement due to normal growth or normal wear and tear.

   Coverage is for standard equipment only.

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

4. **Wigs** or hairpieces when prescribed by a Physician for hair loss due to injury, chemotherapy or otherwise provided under the clinical policies of the Claims Administrator, up to one wig or hairpiece every two years. Any limitations are listed in the Schedule of Benefits.

Prescription Drug Benefits

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements.

Covered Prescription Drugs

If You or any one of Your Dependents, while insured for Prescription Drug Benefits, incurs expenses for Charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a practitioner licensed to prescribe, We will provide coverage for those expenses as shown in the Schedule of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

You must show Your ID card to a retail Pharmacy at the time You obtain Your Prescription Drug or You must provide the Pharmacy with identifying information that can be verified by Us during regular business hours.

To be a covered service, the Prescription Drug or medicine must be:

- Purchased from a licensed retail or mail order Pharmacy;
- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- Dispensed by a licensed Pharmacy.
- If purchased outside of the United States, the purchase and distribution is subject to the local laws and local jurisdictional responsibilities;
- Not prohibited by law.

Covered Prescription Drugs include, but are not limited to:

1. Self-injectable/administered Prescription Drugs.
2. Self-injectable insulin and supplies and equipment used to administer insulin including syringes;
3. Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
4. Inhalers (with spacers).
5. Topical dental preparations.
6. Pre-natal vitamins.
7. Osteoporosis drugs approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
8. Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.

9. Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and non-immunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
10. Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
11. Prescription Drugs prescribed in conjunction with treatment or services covered under the Infertility treatment benefit, including in vitro fertilization, in the Outpatient and Professional Services section of this Certificate.
12. Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
13. Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
14. Appropriate pain management medications for terminally ill patients.
15. Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
16. Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
17. Contraceptive drugs, devices and other products without Deductibles, Copayments or Coinsurance, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over the counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.
18. Medication for pre-exposure prophylaxis (PrEP) without Copayment or cost-sharing for individuals who, according to their provider or pharmacist, are indicated for PrEP.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.bcbsglobalsolutions.com. You may inquire if a specific drug is covered under this Certificate by contacting Us at the number on Your ID card.

Administered by a Medical Provider

This Plan also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an Outpatient facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Participating Provider orders the Drug and administers it to You and is paid as a Medical Expense

Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Injectable Drugs) are covered under the Prescription Drug Benefits.

Definitions

To understand the Your Prescription Drug Benefits, it may be helpful to review these important terms:

Brand-Name Drug is a Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, Pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

Compound Drugs or Compound Medicines means a compounded prescription that is the result of mixing two or more drug ingredients into a final dosage form (tablet, capsule, liquid, suspension, cream, ointment, gel, etc.). The act of compounding is a practice in which a licensed pharmacist, a practitioner licensed to prescribe, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

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

For purposes of this benefit, insulin is considered a Prescription Drug.

Fixed Dose Combination Drugs means manufactured fixed dose combination medicines that because of unique formulation characteristics permits market exclusivity for these medicines and single source brand drug status.

Formulary is the list that identifies those Prescription Drugs for which coverage may be available under this Certificate. To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.bcbsglobalsolutions.com or call the number on Your ID card.

Generic Drug is a Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, Pharmacy or Your Physician may not be classified as a Generic Drug by Us.

Injectable Drug is a drug that can be put into the body with a needle or syringe. The medicine is put under the skin, or into a vein.

Maintenance Drug is a Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

Non-Participating Pharmacy is a Pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Covered Persons.

A **Non-preferred Brand Name Prescription Drug** is one either not included on the Plan's formulary or list of preferred prescriptions. Non-preferred Brand Name Prescription Drugs have a higher Coinsurance than Preferred Brand Name Prescription Drugs. You pay more if You use non-preferred drugs than if You opt for Generics and Brand Name Prescription Drugs. These drugs are generally covered as a Tier 3 drug.

Participating Pharmacy is a Pharmacy that has:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

Pharmacy means a licensed retail Pharmacy, or a home delivery (mail order) Pharmacy.

Preferred Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer.

Prescription means a written order by a practitioner licensed to prescribe.

Prescription Drug is a medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Drug Cost is the amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies; as contracted between Us and Our Pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

Prescription Order or Refill is the directive to dispense a Prescription Drug issued by a duly licensed health care professional who is acting within the scope of their practice.

Specialty Drugs are "bioengineered" oral or injectable medicines that target and treat complex medical conditions including: blood disorders, cancers, Infertility, hormone or enzyme deficiencies, multiple sclerosis, rheumatoid arthritis, and a growing list of obscure or "orphan" diagnoses. Specialty drugs are complex compounds and some have unique "handling" requirements. The FDA in selected situations has required dispensing from a single Pharmacy or a limited set of "approved" pharmacies. Some "specialty" drugs are oral tablets or capsules while others require injection.

Therapeutically Equivalent is when a Prescription Drug has essentially the same efficacy and adverse effect profile.

Benefit and Payment Information

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail, or mail order Pharmacy.

   For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits.

   You are responsible for paying the full cost (the amount the Pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Allowed Amount of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required In-Network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card or visit Our website at www.bcbsglobalsolutions.com to request approval.

3. **Non-Participating Pharmacies.** If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy. We will not pay for any Prescription Drugs that You purchase at a Non-Participating mail order Pharmacy.

4. **Outside the United States Pharmacies.** If You purchase a Prescription Drug from a Pharmacy outside of the United States, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Provider licensed in their jurisdiction, We will provide coverage for those expenses as shown in the Schedule of Benefits. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Allowed Amount of the Prescription Drug.)

5. **Formulary Changes.** Our Formulary is subject to Our periodic review and modification. Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

   Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

   We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly. These changes may happen without prior notice to You.

   When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for You is a determination that is made by You and Your prescribing Physician.

   The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, You may be required to pay more or less for that Prescription Drug Product. Please contact us at www.bcbsglobalsolutions.com or the telephone number on your ID card for the most up-to-date tier placement.

6. **Tier Status.** Before We move a Prescription Drug to a different tier, We will provide at least 90 days' notice prior to the start of the Policy Year. We will also post such notice on Our website at www.bcbsglobalsolutions.com. If a Prescription Drug is moved to a different tier during the Policy Year for one of reasons described above, We will provide at least 30 days' notice before the change is effective. You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status on Our website at www.bcbsglobalsolutions.com or by calling the number on Your ID card.

7. **Off Label Cancer Drug Usage.** Coverage for Prescription Drugs is provided for drugs being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Drug Utilization Review

We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, the prescribing practitioner may be asked to provide more information before a decision regarding Medical Necessity can be determined. Quantity and or age limits may be set for specific Prescription Drugs or use recommendations made as part of the Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Preauthorization, use of a Prescription Drug List or formulary, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will also be told about any details We would need to decide benefits.

A. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We or the Administrator will contact Your Provider to get the details they need to decide if prior authorization should be given. We or the Administrator will give the results of our decision to both You and Your Provider. The prior authorization process is also used to approve requests from Your Provider for contraceptive methods that are Medically Necessary for You based on Your medical or personal history. For medication assisted treatment of substance use disorders, any FDA approved medication on Our formulary is exempt from prior authorization.

Preauthorization procedures and requirements for coverage are based on clinical need and therapeutic rationale. Administration of the prior authorization process considers the desired outcome for the patient, the design of the drug benefit, the value to Us, and all statutory and regulatory requirements. The process offers the prescriber an opportunity to justify the therapeutic basis for the prescribed medication and receive information concerning the acceptance and payment of claims for a particular drug.

You may need to try a Drug other than the one originally prescribed if We determine that it should be clinically effective for You. However, if We determine through the preauthorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring preauthorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, You are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for Your medical condition and You underwent a prior authorization process under a prior Plan which required You to take different Drugs, We will not require You to try a Drug other than the one You are currently taking.)

The preauthorization review process is outlined below:

1. A rejected Prescription Drug claim will initiate a request for preauthorization with a request for patient demographic and necessary clinical data of the practitioner licensed to prescribe.
2. Our Pharmacy Benefit Manager (PBM) reviews available data and determines:
   a. Information provided is sufficient to make a determination;
   b. Information provided is insufficient to make a determination and initiates fax request for necessary clinical data to prescribing practitioner within 24 hours following receipt of review request.
3. Review of historic medication claim data, standard clinical references and clinical data/information received from the practitioner licensed to prescribe.
4. Match of available data and information with labeled indication(s) for prescribed medication requiring authorization and against generally accepted clinical authorization criteria.
5. A recommendation to accept claims for payment will be made in writing and provided to Us and removal of Prior Authorization criteria in the Rx claim system will be completed.
6. A recommendation to not accept claims for payment will be made in writing and provided to will be provided to Us the practitioner licensed to prescribe, the Prescription Drug claims processor and the Covered Person.
7. Review and recommendation to be completed within 48 hours following receipt of clinical data from practitioner.

If preauthorization is denied You have the right to file a grievance as outlined in the Appeals section of this Certificate.

For a list of Drugs that need preauthorization, please call the telephone number listed on Your ID Card or visit www.bcbsglobalsolutions.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which drugs are covered under the Prescription Drug coverage.

B. **Day Supply and Refill Limits.** We cover Refills of Prescription Drugs only when dispensed at a retail, or mail order Pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 180-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 180-day supply at a mail order Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the Pharmacy &Therapeutics (P&T) Committee.

Eye Drops Limitation: You will have a right to a limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. Any refill dispensed prior to the expiration of the approved coverage period will, to the extent practicable, be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

The limitation will not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.

Limitations/Terms of Coverage

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. Compounded Prescription Drugs will be covered only when the primary ingredient is a covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a Pharmacy that is approved for compounding. All compounded Prescription Drugs over $500 require Your Provider to obtain Preauthorization.

3. Fixed Dose Combination Drugs that are not supported by medical and/or pharmaceutical literature describing a therapeutic advantage in clinical outcomes to the same or similar separately administered medicines in comparable daily doses. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a Fixed Dose Combination drug. See the Drug Utilization Review section of this benefit.

4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Covered Persons with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a covered Health Care Service.

6. Injectable drugs (other than self-administered injectable drugs) are not covered under this section but are covered under other sections of this Certificate.

7. General and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered).

8. We do not cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are covered under the Outpatient and Professional Services section of this Certificate.

9. We do not cover drugs that do not by law require a prescription**,** over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate. We do not cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

10. We do not cover Prescription Drugs to increase or enhance sexual performance or treat sexual dysfunction including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

11. We do not cover Prescription Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.

12. We do not cover diet pills or appetite suppressants (anorectics) or weight management drugs.

13. We do not cover a Prescription Drug that contains marijuana, including medical marijuana.

14. We do not cover diagnostic kits and products.

15. We do not cover a Prescription Drug with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to four times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.

16. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

17. Any oral non-sedating antihistamine or antihistamine-decongestant combination.

18. We do not cover Prescription Drugs used to enhance athletic performance.

19. We do not cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.

20. We reserve the right to deny benefits as not Medically Necessary or Experimental / Investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

21. A Pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

22. We do not cover Prescription Drugs to treat an illness or injury that is shown in the Medical "Exclusions" section of Your Certificate.

Reimbursement/Filing a Claim

When You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, You pay any applicable Copayment, or Coinsurance and/or Deductible shown in the Schedule of Benefits at the time of purchase. You do not need to file a claim form.

If You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a Non-Participating Pharmacy, You pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery (mail order) Participating Pharmacy, contact customer service for assistance.

VIII. Limitations/Exclusions (What is Not Covered)

Additional coverage limitations determined by Plan or Provider type are shown in the Schedule of Benefits. Payment for the following is specifically excluded from this Plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if You are legally entitled to such treatment and facilities are reasonably available.
4. For or in connection with an Injury or Sickness which is due to active participation in war, declared or undeclared, or participation in riot, civil commotion or police action or any act of war.
5. For claim payments that are illegal under applicable law.
6. Charges which You are not obligated to pay or for which You are not billed or for which You would not have been billed except that they were covered under this Plan.
7. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
8. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for Medically Necessary medical or behavioral health treatment received in these locations
9. For or in connection with Experimental / Investigational or unproven services.

   Experimental / Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

   - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
   - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
   - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this Plan; or
   - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this Plan.
10. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
11. The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty for cosmetic reasons; redundant skin surgery; removal of skin tags for cosmetic reasons; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe Morbid Obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe Morbid Obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
13. Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
14. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
15. Reversal of male or female voluntary sterilization procedures.
16. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
17. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
18. Non-medical counseling or ancillary services, including but not limited to Custodial Care services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
19. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

20. Family and marital counseling except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Covered Person.
21. Consumable medical supplies other than diabetic supplies, ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this Plan.
22. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
23. Artificial aids including, but not limited to, corrective orthopedic shoes (except for therapeutic footwear for the treatment of diabetes), arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
24. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
25. Vision treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
26. Vision exams, lenses and hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This Plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
27. All non-injectable Prescription Drugs, injectable Prescription Drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-Prescription Drugs, and Experimental / Investigational drugs, except as provided in this Plan.
28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
30. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
31. Dental implants for any condition.
32. Dental services or supplies except as specifically stated.
33. Orthodontia services, regardless of condition, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Cosmetics, dietary supplements and health and beauty aids.
37. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
38. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
39. Vitamins, food supplements or for experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and B-12 injections which are covered.).
40. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit. This exclusion does not apply if the Group does not furnish Worker's Compensation or Defense Based Act insurance.

General Limitations

No payment will be made for expenses incurred for You or any one of Your Dependents:

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

IX. Member Payment Responsibility

The Schedule of Benefits section of this Certificate explains the types of expenses You must pay for covered services before the benefits of this Plan are provided. The benefits and limits stated in the Schedule of Benefits are per Covered Person unless specifically stated otherwise.

To prevent unexpected Out-of-Pocket Expenses, it is important for You to understand what You are responsible for.

Coinsurance
The term Coinsurance means the percentage of Charges for Covered Expenses that a Covered Person is required to pay under the Certificate.

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

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

- Coinsurance
- Plan Deductible
- Copayments
- Prescription Drug Copayments

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Limit, and they are not payable under the Certificate at 100% when the Out-of-Pocket Limit shown in the Schedule of Benefits is reached:

- Provider charges in excess of the Allowed Amount.
- Non-compliance penalties, if any, for failure to follow any Pre-Authorization requirements.
- Non-Covered Expenses.
- Premiums or contributions.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Limits will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Certificate maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

Allowed Amount
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider's Charge, if less.

We reserve the right to negotiate a lower rate with Non-Participating Providers or to pay a Host Blue plan's rate, if lower. If the Provider participates in a Network for an equivalent product offered by an affiliated insurer or HMO in another state, and the Provider has agreed to extend the rate to this Certificate, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. **Facilities.**
   For Facilities, the Allowed Amount will be the lesser of
   - 150% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount for the date(s) on which the services were rendered. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 100% of the average amount We have negotiated with Facilities that are Participating Providers of the same type as the non-Participating Facility or 50% of billed charges, whichever is less;
   - The Facility's Charge;
   - Host Blue plan's rate;
   - an amount based on Our Participating Provider fee schedule or rate; or
   - the average amounts paid by Us for comparable services to Participating Hospitals and or Facilities in the same county. If there are no Participating Hospitals and/or Facilities in the same county, then the average amount paid by Us for comparable services to Participating Hospitals and/or Facilities in the contiguous county or counties.
   - The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.

2. For All Other Providers.

For all other Providers, the Allowed Amount will be the lesser of

- 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 100% of the average amount We have negotiated with Providers that are Participating Providers of the same type as the non-Participating Facility or 50% of billed charges, whichever is less;
- the Provider's Charge;
- an amount based on Our Participating Provider fee schedule or rate; or
- the average amounts paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.

For Durable Medical Equipment, a prosthetic device or implant, if there is no code listed or source pricing, the Allowed Amount will be 2.0 times the manufacturers' invoice price or 50% of billed charges, whichever is less.

3. Physician-Administered Pharmaceuticals.

For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

4. The Allowed Amount for Covered Services incurred outside of the United States will be determined as follows:
   - For Providers or Facilities contracted with our claims administrator, the Allowed Amount for care delivered outside of the United States will be the lesser of the amount billed by the Provider or Facility, as reflected on the verifiably provided bill, or the contracted amount that Provider or Facility has agree to in writing with our claims administrator.
   - For Providers or Facilities not contracted with our claims administrator, the Allowed Amount for care delivered outside of the United States will be the lesser amount billed by the Provider or Facility, as reflected on the verifiably provided bill, or the most common charge for a particular medical service when rendered in a particular geographic area. The Allowed Amount will not exceed the amount ordinarily charged by most Providers for comparable services and supplies in the locality where the service or supplies are received.

   We reserve the right to verify and audit any medical bills prior to reimbursement.

Our Allowed Amount is not based on usual and customary charge. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website on the back of Your ID Card for information on Your financial responsibility when You receive services from a Non-Participating Provider.

X. Claims Procedure (How to File a Claim)

Claim Process

Notice of Claim: Within twenty (20) days after a Covered Person receives covered services, or as soon as reasonably possible, they or someone on their behalf, must notify Us in writing of the claim.

Within fifteen (15) days after We receive the Covered Person's written notice of claim, We must:

a. acknowledge receipt of the claim;
b. begin any investigation of the claim;
c. specify the information the Covered Person must provide to file proof of loss. (We can request additional information during the investigation if necessary.)
d. send the Covered Person any forms We require for filing proof of loss. If We do not send the forms within this time period, the Covered Person can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of the Covered Person's claim. The Covered Person must give this letter within the time period for filing proof of loss.

Proof of Loss: Within ninety (90) days after the Covered Person receives covered services, they must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible. Unless the Covered Person is not legally capable, the required proof must always be given to Us no later than one calendar year from the date otherwise required.

All benefits payable under the Plan will be payable immediately upon receipt of written proof of such loss. Should We fail to pay the benefits payable under the Plan, We shall have fifteen (15) workings days thereafter within which to mail the Covered Person a letter or notice which states the reasons We may have for failing to pay the claim, either in whole or in part, and which also gives the Covered Person a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim has been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving the Covered Person the reasons We may have for denying such claim or any portion thereof.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as We receive proper written proof of such loss. Any benefits payable to the Covered Person and unpaid at the Covered Person's death will be paid to the Covered Person's estate.

Payment of Claims: We may pay all or a portion of any indemnities provided for Health Care Services to the participating Health Care Services Provider, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for Health Care Services by a nonparticipating Health Care Services Provider directly to the Covered Person, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular Health Care Services Provider.

Payment of Benefits – To Whom Payable: Medical benefits are payable to You or Your assignee but generally are assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a Covered Person's payment on the charge, it is the Provider's responsibility to reimburse the Covered Person. Because of the contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You or Your assignee for the cost of any Covered Expenses from a Physician or Other Health Care Provider who provides Health Care Services to You. When benefits are paid to You, Your assignee or Your Dependent, You, Your assignee or Your Dependents are responsible for reimbursing the Provider.

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

When a Covered Person passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as a Covered Person and benefit payments for unassigned claims should be made payable to the executor.

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

Payment to a Managing Conservator: Benefits paid on behalf of a covered Dependent Child may be paid to a person who is not the insured Participant 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 Us 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 insured Participant where the insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Misstatement of Age: If the age of a Covered Person has been misstated, an adjustment of premiums shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

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

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

Physical Exam and Autopsy: We have the right to require a medical examination, at reasonable intervals, or an 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.

Required Information: The Group will furnish Us all information necessary to calculate the Premium and all other information that We may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. We have the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan. Our right to examine any records that exist:

- During the time the Plan is in force; or
- Until We pay the last claim.

We are not responsible for any claim for damages or injuries suffered by the Covered Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and Providers act as independent contractors and not as Employees, agents or representatives of Us.

We are entitled to receive from any Provider of service information about the Covered Person which is necessary to administer claims on the Covered Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Covered Person has authorized every Provider furnishing care to disclose all facts pertaining to the Covered Person's and their insured Dependent's care, treatment, and physical condition, upon Our request. The Covered Person agrees to assist in obtaining this information if needed.

Right of Recovery

We have the right to recover amounts We paid that exceed the amount for which We are liable. Such amounts may be recovered from the Participant or any other payee, including a Provider. Or, such amounts may be deducted from future benefits of the Participant or any of their Dependents (even if the original payment was not made on that Covered Person's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a Provider that does not have a contract with Us.

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

XI. General Policy Provisions

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions
The meanings of key terms used in this Part IX. are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When the Insured sees these capitalized words, then he/she should refer to this Definitions provision.

(a) A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   (1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred Provider benefit plans and exclusive Provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.
   (2) Plan does not include: disability income protection coverage; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and Custodial Care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

(b) "This Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

   The order of benefit determination rules determine whether This Plan is a primary plan or secondary plan when the Covered Person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits equal 100 percent of the total Allowable Expense.

(c) "Allowable Expense" is a health care expense, including deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable Expense. In addition, any expense that a health care Provider or Physician by law or in accord with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:
   (1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
   (2) If a Covered Person is covered by two or more Plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   (3) If a Covered Person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a Covered Person is covered by one Plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, Allowed Amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another Plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the Allowable Expense for all Plans. However, if the health care Provider or Physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care Provider's or Physician's contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior authorization of admissions, and preferred Provider and Physician arrangements.

(d) "Allowed Amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a non-preferred health care Provider or Physician. The Allowed Amount includes both the carrier's payment and any applicable Deductible, Copayment, or Coinsurance amounts for which the Covered Person is responsible.

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

(f) "Custodial Parent" is the parent with the right to designate the primary residence of a child by a court order or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of Benefit Determination Rules

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

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(b) Except as provided in (c), a Plan that does not contain a COB provision that is consistent with this Policy is always primary unless the provisions of both Plans state that the complying Plan is primary.

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

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

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a Covered Person uses a non-contracted health care Provider or physician, except for Emergency Services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single Plan under this subchapter, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter.

(g) If a Covered Person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decides the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each Plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an Employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Plan that covers the Covered Person as a dependent is the secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent and primary to the Plan covering the Covered Person as other than a dependent, then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an Employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Plan is the primary plan. An example includes a retired Employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, Plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
  (i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
  (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
  (i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree.
  (ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
  (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.
  (iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    (I) the Plan covering the custodial parent;
    (II) the Plan covering the spouse of the custodial parent;
    (III) the Plan covering the noncustodial parent; then
    (IV) the Plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents' Plans and has his or her own coverage as a dependent under a spouse's Plan, (h)(5) applies.

(E) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The Plan that covers a Covered Person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The Plan that covers that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a dependent of an active Employee and that same person is a dependent of a retired or laid-off Employee. If the Plan that covers the same person as a retired or laid-off Employee or as a dependent of a retired or laid-off Employee does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, member, subscriber, or retiree or covering the person as a dependent of an Employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that has covered the Covered Person as an Employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the Covered Person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

(a) When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel Provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. 4 Ever Life or its Administrator will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the Covered Person claiming benefits. Each Covered Person claiming benefits under This Plan must give 4 Ever Life or its Administrator any facts it needs to apply those rules and determine benefits.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, 4 Ever Life or its Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. 4 Ever Life or its Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by 4 Ever Life or its Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Medicare Eligible Insured Participants
Covered Persons eligible for Medicare receive the full benefits of this Plan, except for those Covered Persons listed below:
1. Covered Persons who are receiving treatment for end-stage renal disease following the first 30 months such Covered Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Covered Persons who are entitled to Medicare benefits as disabled persons, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more Employees (subject to COBRA legislation).
3. Covered Persons who are entitled to Medicare for any other reason, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more Employees (subject to COBRA legislation).

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

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

Third Party Liability

This Plan does not cover:
- Expenses incurred by You or Your Dependent (individually and collectively referred to as a "Participant," in this section) for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness and which is not subject to the Coordination of Benefits Section.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance coverage.

Subrogation/Right of Reimbursement
If a Participant incurs a Covered Expense for which, in the opinion of the Plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:
- Subrogation: The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan limited to the proportional amount allowable under law or the amount of the recovery less any attorney's fees and procurement costs. A Participant or their representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- Right of Reimbursement: The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise, subject to any limitations on recovery as required or allowed by law (Civil Practice and Remedies Code). This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

Lien of the Plan
By accepting benefits under this Plan, a Participant:
- grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with their reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Other Provisions

Entire Contract and Changes: The entire contract between the Group and Us is as stated in the Policy and the entire contract between the Covered Person and Us is as stated in the Certificate of Coverage including the endorsements, application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of Our officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

Grace Period: There is a Grace Period of thirty-one (31) days allowed for the payment of each premium after the first premium, during which time the Policy continues in force.

Representations: All statements made by a Covered Person or the Group shall be considered representations and not warranties. We must provide the Covered Person or the Group with a copy of any statements used to contest coverage.

Time Limit on Certain Defenses/Misstatements on the Application: After two (2) calendar years from the effective date of the Policy, We will not contest the validity of the Policy. After two (2) calendar years from the Participant's effective date of coverage, no misstatements on the Participant's application may be used to:

a. void this coverage, or
b. deny any claim for loss incurred or disability that starts after the two (2) Calendar Year period.

The above does not apply to fraudulent misstatements.

Legal Actions: The Covered Person cannot file a lawsuit before sixty (60) days after We have been given written proof of loss. No action can be brought after three (3) calendar years from the time that proof is required to be given.

Conformity with State Statutes: If any provision of this Plan which, on its effective date, is in conflict with the statutes of the state in which the policyholder resides, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

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

XII. Termination/Nonrenewal/Continuation

Events That End Coverage

Coverage will end without notice, except as specified under "Medical Benefits Extension," on the last day of the month in which one of these events occurs:

- For the Participant and Dependents when:
  - The Group Policy is terminated;
  - The next monthly premium is not paid when due or within the grace period;
  - The Participant dies or is otherwise no longer eligible as a Participant;
  - In the case of a collectively bargained plan, the Employer fails to meet the terms of an applicable collective bargaining agreement or to employ the Employee covered by a collective bargaining agreement.
- For a spouse when their marriage to the Participant is annulled, or when they become divorced from the Participant, or for a domestic partner upon termination of the domestic partnership arrangement.
- For a Child when they cannot meet the requirements for Dependent coverage shown under the "Who Is Eligible For Coverage?" section. Coverage will end the last day of the month they no longer qualify as a Dependent.

The Participant must promptly notify the Employer when a Dependent is no longer eligible to be enrolled as a Dependent under this Plan. The Employer must give Us written notice of a Covered Person's termination within 30 days of the date the Employer is notified of such event.

Temporary Layoff or Leave of Absence

If Your Active Service ends due to temporary layoff, furlough or leave of absence, Your insurance will be continued until the date the Employer (a) stops paying premium for You; or (b) otherwise cancels Your insurance. However, Your insurance will not be continued for more than 60 days past the date Your Active Service ends.

Injury or Sickness

If Your Active Service ends due to an Injury or Sickness, Your insurance will be continued while You continuously remain Totally Disabled as a result of the Injury or Sickness. However, Your insurance will not continue past the date the Employer stops paying premium for You or otherwise cancels Your insurance.

Policy Termination

No rights are vested under this Plan. Termination of the Group Policy for this Plan completely ends all Covered Persons' coverage and all of our obligations, except as provided under "Medical Benefits Extension".

The Policy is guaranteed renewable. However, this Plan will automatically terminate if premiums are not paid when due; coverage will end on the last day for which payment was made. This Plan may also terminate as indicated below.

The Group may terminate the Group Policy:

- Effective on any premium due date, upon 30 days' advance written notice.
- By rejecting in writing the Policy changes We make after the initial term. The written rejection must reach Us at least 15 days before the changes are to start. The Group Policy will end on the last date for which premiums were paid.

We may terminate the Group Policy, upon 30 days advance written notice to the Group:

- For non-payment of premium;
- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application;
- There is a material breach of the Group Policy, other than non-payment;
- Changes in or implementation of federal or state laws that no longer permit the continued offering of the Group Policy;
- We discontinue this Group Policy, as allowed by law;
- We are otherwise permitted to do so by law.

Termination will not affect a claim for benefits for Covered Services received while Your insurance was in force under the Group Policy.

We may refuse to renew the coverage of a Participant or covered Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Refusal to Renew; Discontinuance of Coverage: We may refuse to renew this Group Policy, as allowed by law, provided:

- We give the Group and the Commissioner written notice of uniform discontinuance of coverage at least 90 days in advance of the date coverage terminates; and
- We offer to each Group the option to purchase any other large group health plan currently being offered by Us at the time of discontinuance.

Continuation of Coverage under State Law

State continuation ensures that coverage continues under the Policy when it would otherwise end. You (and Your Dependents if currently covered under the Policy) are entitled to continue coverage if all the following criteria apply:

- Termination is due to any reason other than involuntary termination for cause, including discontinuance of the Policy in its entirety or with respect to an insured class; and
- You were continuously covered under the Policy (or under the Policy and any similar group plan which was replaced by this Policy) for the entire 3 month period before the termination of employment.

Involuntary termination for cause does not include termination for any health-related cause.

The Employer is responsible for providing You with all requisite notices and the request form. You have 60 days to provide the Employer or the designated administrator with the written request for continuation of coverage. This period is measured from the later of:

- The date coverage under the Policy would otherwise end, or
- The date the request form is sent to You.

The Insurer will not provide state continuation coverage for any Covered Person if You fail to:

- Provide a valid, signed request form within the 60 days immediately following the receipt of a request form; and
- Pay the requisite premium due within 45 days of the date of election to continue coverage and continue to pay subsequent premium when due to keep continuation coverage in force.

The request form provided by the Employer or their designated administrator will set forth the requirements for electing state continuation coverage and the cost of coverage. The cost of coverage will not exceed the total premium for current coverage plus 2% of the group rate for the coverage being continued. The first premium must be paid within 45 days of the election date. This continuation option ends and coverage ends if You fail to elect continuation within the specified time period or pay the initial premium when due.

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

1. The maximum period required by law as follows:
    a. For any person not eligible for COBRA Continuation, 9 months after the date the Covered Person elects to continue the group coverage; and
    b. For any person eligible for COBRA Continuation, 6 additional months following any period of continuation coverage provided under COBRA;
2. the date failure to make timely payments would terminate the Group coverage, subject to the Grace Period Provision;
3. the date the Group coverage terminates in its entirety;
4. the date the Covered Person is or could be covered under Medicare;
5. the date the Covered Person becomes covered for similar benefits by another plan or program, including:
    a. A hospital, surgical, medical, or major medical expense insurance policy;
    b. A hospital or medical service subscriber contract; or
    c. A medical practice or other prepayment plan;
6. the date the Covered Person is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
7. the date similar benefits are provided or available to the Covered Person under any state or federal law.

Continuation of Coverage after Death or Retirement of a Participant or Dissolution of Marriage

A Covered Person whose coverage would otherwise terminate on the date of a Participant's death, retirement or the date of dissolution of marriage may elect state continuation coverage under the Policy if:

1. The Dependents have been covered under the Plan for one year (or is an infant under one year of age); and
2. make timely request for continuation as explained below.

A Covered Person must provide written notice to the Group within 15 days of the Participant's death, retirement or the date of dissolution of marriage. Upon receipt of such notice, the Group must immediately give written notice of the continuation option to each affected Dependent of the Participant. The notice shall include:

1. A form for election to continue coverage;
2. The amount of premium for continued coverage and the method and place of payment;

Within 60 days of receipt of the notice, the Dependent must give written notice to the Group of their intent to elect state continuation. Coverage under the Policy remains in effect during the 60 day election period provided the required premium is paid.

Failure to return the election form and pay the initial premium within 60 days after receipt of the notice shall terminate the continuation of coverage and the right to state continuation.

Coverage under this section will be continued until the earliest of:
1. Three years from the date of the Participant's death or retirement or the date of dissolution of marriage;
2. The date the Covered Person fails to make timely payment of premium;
3. The date the Covered Person becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan.

Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Policy or was no longer eligible for coverage. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If an individual's coverage is going to be rescinded, the individual will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered an Adverse Benefit Determination that can be appealed according to the rules described in this Policy.

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation

If the medical benefits under this Policy cease for You or Your Dependent due to cancellation of the Policy (except if the Policy is canceled for nonpayment of premiums) and You or Your Dependent is Confined in a Hospital on that date, Medical benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date You exceed the Maximum Benefit, if any, shown in the Schedule of Benefits;
- the date You are covered for medical benefits under another group plan;
- the date You or Your Dependent is no longer Confined in a Hospital; or
- 90 days from the date the Policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when Your medical benefits cease or Your Dependent's medical benefits cease.

XIII. Utilization Review and Case Management

Utilization Review
This term refers to the programs that We use to evaluate the necessity and appropriateness of Your Health Care Services and supplies. We use a set of formal techniques that are designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of Health Care Services, procedures or settings, and drugs. This review includes health services to determine whether the services are or were Medically Necessary or Experimental/Investigational ("Medically Necessary"). These programs are designed to encourage appropriate care and services (not less care).

Utilization Review includes all review activities, whether they take place prior to the service being performed (Precertification); when the service is being performed (Concurrent); or after the service is performed (Retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the Health Care Service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our Employees or reviewers for determining that services are not Medically Necessary.

Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.bcbsglobalsolutions.com.

Precertification/Precertify
Certain services require Precertification by Us. The term Precertification means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Certificate. Precertification is a process that helps You and Your physician determine whether the services being recommended are Covered Expenses under the Certificate. It also allows Us to help Your Provider coordinate Your transition from an Inpatient setting to an Outpatient setting (called discharge planning), and to register You for specialized programs or case management when appropriate.

You do not need to Precertify services provided by a Network Provider. Network Providers will be responsible for obtaining the necessary Precertification for You. Since Precertification is the Provider's responsibility, there is no additional Out-of-Pocket cost to You because of a Network Provider's failure to Precertify services.

When You go to an out-of-Network Provider, it is Your responsibility to obtain Precertification from Us for any services or supplies on the pre-certification listed in this section. If You do not Precertify, Your benefits may be reduced, or the plan may not pay any benefits.

> **Important Note:** Please read the following sections in their entirety for important information on the Precertification process, and any impact it may have on Your coverage. Please see the Schedule of Benefits for the Penalty or benefit reduction that applies to Your plan, if any. It is important to remember that any penalties or benefit reductions incurred because Your Precertification requirement was not met will not count toward Your Deductible or Out-of-Pocket Limit.

The Precertification Process
Prior to being hospitalized or receiving certain other medical services or supplies there are certain Precertification procedures that must be followed.

You do not need to Precertify services provided by a Network Provider. Network Providers will be responsible for obtaining the necessary Precertification for You. Since precertification is the provider's responsibility, there is no additional Out-of-Pocket cost to You because of a Network Provider's failure to Precertify services.

When You go to an out-of-network Provider, it is Your responsibility to obtain Precertification from Us for any services or supplies on the Precertification listed in this section. If You do not Precertify, Your benefits may be reduced, You may incur a penalty, or the Certificate may not pay any benefits. You or a member of Your family, a hospital staff member, or the attending physician, must notify Us to Precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require Precertification pursuant to this Certificate in accordance with the following timelines:

Services and Supplies that Require Precertification
Some services or supplies in this list may not be covered by the Certificate. Please check the benefits as listed in the Schedule of Benefits and the Exclusions and Limitations listed. This list is subject to change. The most recent list is available by calling the number on Your ID card.

Precertification is required for the following types of medical expenses:

- All Inpatient Hospital services, including: acute habilitation admissions; elective surgical and nonsurgical Inpatient Admissions; Inpatient hospice admissions; long term acute care facility admissions; Skilled Nursing Facility admissions; Inpatient/Partial Hospitalization programs/intensive Outpatient programs; resident treatment facilities.
- Day rehabilitation programs
- Home Health Care Services.
- Outpatient private-duty nursing.

- Interventional pain management services.
- Advanced radiological imaging, including CT and CTA scans, MRAs and MRIs, PET and PETT scans, and single photon emission computerized tomography (SPECT), technetium or thallium.
- Elective/non-emergency ground, air and sea ambulance transportation.
- Obesity surgery, including bariatric surgery; cochlear implant surgery; carticel (ACI), osteochondral allograft, and autograft transplantations.
- Reconstructive procedures that might be considered cosmetic procedures: examples include, but are not limited to: blepharoplasty, bone grafts, breast reconstruction, gender reassignment surgery, rhinoplasty, surgery for varicose veins.
- Any procedure, device or service that may be considered Experimental / Investigational including: new emergent technology/procedures, as well as existing technology and procedures applied for new use and treatments.
- Any Durable Medical Equipment more than $500, including, but not limited to: insulin pumps; CPAP or Bi-PAP devices; electric, power and motorized wheelchairs; external defibrillators; speech generating devices.
- Custom prosthetics/orthoses.
- Certain genetic and genomic tests.
- Hyperbaric oxygen therapy.
- Proton beam therapy.
- Sleep studies (facility based).
- Specialty Drugs – for a list of specialty drugs, please call the number on the back of Your ID card. That list is subject to change.
- Transplant services with the exception of corneal transplants.

Providers should be prepared to provide the following information for the request:
- Patient's medical or behavioral health condition
- Proposed treatment plan
- Date of service, estimated length of stay (if the patient is being admitted)
- Patient ID and name/date of birth
- Place of treatment
- Provider NPI, name and address
- Diagnosis code(s)
- Procedure code(s) (if applicable)

Renewal of an existing prior authorization can be requested up to 60 days before the expiration of the existing prior authorization.

Precertification should be secured within the timeframes specified below. To obtain Precertification, call Us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, Your Physician or the Facility will need to call and request Pre-certification at least 14 days before the date You are scheduled to be admitted.
For an emergency Outpatient medical condition:	You or Your Physician should call prior to the Outpatient Care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, Your Physician or the Facility must call within 48 hours or as soon as reasonably possible after You have been admitted.
For an urgent admission:	You, Your Physician or the Facility will need to call before You are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of or change in an illness; the diagnosis of an illness; or an Injury.
For Outpatient non-emergency medical services, equipment or supplies, or for all other medical services requiring Pre-certification:	You or Your Physician must call at least 14 days before the Outpatient Care is provided, or the treatment or procedure is scheduled.

Concurrent Review
Concurrent Review means that while You are an Inpatient, We will monitor and review the Health Care Services You receive to make sure You still need Inpatient coverage in that Facility. In some cases, We may determine upon review that You will need to continue Inpatient coverage in that health care Facility beyond the number of days first thought to be required for Your condition. When We make this decision (within one working day of receiving all necessary information), We will let the health care Facility know of the coverage approval status of the review. We will also send a written (or electronic) notice to You and to the Facility to explain the decision. This notice will be sent within one working day of that first notice. This notice will include: the number of additional days that are being approved for coverage (or the next review date); the new total number of approved days or services; and the date the approved services will begin.

In other cases, based on a Medical Necessity determination, We may determine that You no longer need Inpatient coverage in that health care Facility or, You may no longer need Inpatient coverage at all. We will make this decision within one working day of receiving all necessary information. We will call the health care Facility to let them know of this decision and We will discuss plans for continued coverage in a health care setting that better meets Your needs.

Retrospective Review
If neither Precertification nor Concurrent Review were performed, We will use Retrospective Review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Certificate. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.

Retrospective Review of Precertified Services
We may only reverse a Precertified treatment, service or procedure on Retrospective Review when:

- The relevant medical information presented to Us upon Retrospective Review is materially different from the information presented during the Precertification review;
- The relevant medical information presented to Us upon Retrospective Review existed at the time of the Precertification but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Precertification review; and
- Had We been aware of such information, the treatment, the service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Precertification review.

Important Information if You Choose to Appeal
You or someone acting on Your behalf and the Provider of record have the right to appeal the Adverse Determination (denial) orally or in writing. A Physician who has not previously reviewed the case will make the appeal decision. The appealing party must send Us the appeal no later than 180 days after the date of this letter. At any time, You have the opportunity to submit additional written comments, documents, and/or other information pertaining to Your claim for review. At Your request, We will provide access to, and copies of, all relevant documents, records, and other information at any time to You or Your authorized representative free of charge.

For Medical Necessity issues, should You desire more information about the decision and/ or a free copy of the description of, or the source of, the screening criteria that We utilized in making the determination, please send a written request to our Utilization Review Agent (URA) including the reference number found at the top of the determination letter to "Clinical Rationale" at the address provided below.

Medical Necessity Appeal
Our formal process by which You, an individual acting on Your behalf, or Your Provider of record may request reconsideration of an Adverse Determination based upon Medical Necessity or, decisions that were made based upon identification of treatment as cosmetic or Experimental / Investigational. Appeal decisions are made by Physicians in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment and is neither the Physician who has previously reviewed the case nor a subordinate of such Physician.

Administrative (Complaint)
Complaint - An oral or written expression of dissatisfaction with our contracted URA concerning their process in conducting a utilization review.

At any time during the appeal process, You or an individual acting on Your behalf may request the aid of an employee of our URA in preparing or presenting Your appeal at no charge. This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file. If You would like assistance in preparing Your appeal, please call the number listed below.

To file an appeal of this determination, call, write or fax a request to:

Blue Cross Blue Shield Global Solutions
c/o AmeriHealth Administrators
Appeals Department
PO Box 21545
Eagan, MN 55121
Phone: 1-855-282-3517
Fax: 215-761-0956

Internal Appeals – Standard and Expedited

Standard Appeals

Medical Necessity (Pre-service or Post-service)

Pre-service – An appeal for benefits that, under the terms of this Certificate, must be pre-certified or preapproved before medical care is obtained in order for coverage to be available.

- You have one (1) level of internal standard appeal of an Adverse Determination involving non-urgent pre-service care. Standard appeals are resolved within Thirty (30) days of receipt of the appeal.

Post-service (Retrospective) – An appeal concerning claims that have been received for services that the Covered Person has already obtained.

- You have one (1) level of internal standard appeal of an Adverse Determination involving non-urgent post-service care. Standard appeals are resolved within thirty (30) days of receipt of the appeal. We may also extend this deadline once for a period not to exceed fifteen (15) days.

Specialty Appeal
The Provider of record may request a specialty appeal, which requests that a specific type of specialty Provider review the case. The Provider must request this type of appeal within 10 working days from the date the appeal was requested or denied. We will complete the specialty appeal and send our written decision to You or the person acting on Your behalf and the Provider within 15 working days of receipt of the request for the specialty appeal.

Urgent Care / Expedited Appeals
An expedited appeal is available for a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care Provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the Covered Person. An expedited appeal is also available for denials of Prescription Drugs and intravenous infusions for which the Covered Person currently receiving benefits and for denied step therapy protocol exception requests.

An Urgent Expedited Appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Your one (1) level of Internal Expedited Appeal is completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received. An expedited appeal is also available for denials of Prescription Drugs and intravenous infusions for which the Covered Person is currently receiving benefits. Review is completed by a health care Provider who has not previously reviewed the case and is of the same or a similar specialty as the health care Provider who would typically manage the medical or dental condition, procedure, or treatment including Prescription Drugs and intravenous infusions under review in the appeal. We may provide the determination by telephone or electronic transmission, but written notification is provided within three (3) business days of the initial telephonic or electronic notification.

> **Note:** If You believe Your situation is urgent, You may request an Expedited External Review. You have the right to file an Expedited External Review facilitated by our URA. Please see below for more information about the independent review.

Life-Threatening Conditions: "Life Threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.
If You have a life-threatening condition or receive a denial for Prescription Drugs or intravenous infusions for which You are currently receiving benefits, You, or someone acting on Your behalf, and the Provider of record can request an immediate review by an Independent Review Organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

Acquired Brain Injury Appeal:
Appeal requests for Acquired Brain Injury are completed no later than three (3) business days after the date on which an individual requests utilization review or requests an extension of coverage based on Medical Necessity or appropriateness. Notification of the determination is made through a direct telephone contact to the individual making the request. Written notification will be provided within 30 calendar days of appeal request.

> **Note:** Acquired Brain Injury Appeal does not apply to a determination made for coverage under a small employer health benefit plan.

Exhaustion of Internal Appeals
We will not require exhaustion of Our internal appeals process if: (a) We fail to meet Our internal appeal process timelines, or (b) You have an Urgent Care situation and file an external review before exhausting Our internal appeal process, or (c) We decide to waive the appeal process requirements.

Information About External Review
You have only one (1) level of External Review with an Independent Review Organization (IRO). An External Review process is available for any adverse benefit determination that involves medical judgment as determined by the external reviewer.

External Review Option

THIS OPTION MUST BE COMPLETED WITHIN 180 DAYS FROM THE DATE YOUR INSURER SENT YOU A FINAL DECISION DENYING YOUR SERVICES.

- **HHS-administered Federal External Review**
  For a standard IRO review, You or someone You name to act for You may file a request for external review within four months of receiving this letter. If You would like to have another person make an external review request on Your behalf, both You and Your authorized representative will need to complete and sign the Health and Human Services (HHS) Federal External Review Process Appointment of Representative Form.

  Information on the HHS-Administered Federal External Review Process can be found here: FERP Home (cms.gov)

  If You believe Your situation is urgent, You may request an expedited external review by calling the number below immediately to begin the process. If You want to send more information to include in the review, You can send it with Your request. You may use a HHS Federal External Review Request Form to provide this and other additional information.

  Phone: 1-888-866-6205 M-F 8:00am – 5:00pm EST Fax: 1-888-866-6190
  Mail: MAXIMUS Federal Services
  3750 Monroe Avenue, Suite 705
  Pittsford, NY 14534

  When MAXIMUS Federal Services receives Your request, they will notify Us and we'll send them all of the case information for review. If You send them any more information, they'll share it with us. We may change our decision. If not, the IRO will continue the review. You'll receive a letter with their decision. If MAXIMUS Federal Services decides to overturn our decision, We will provide coverage or payment for Your health care item or service.

Complaint Procedures:
- **You can send a complaint to us (the URA):** You or someone acting on Your behalf, and health care Providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file Your oral or written complaint. We will respond to Your complaint in writing within 30 days.

If Your plan fails to "strictly adhere" to the internal appeals process, You may initiate an external review or file appropriate legal action under state law or ERISA unless:
- Violation was de minimis (minimal).
- Did not cause (or likely to cause) prejudice or harm to the claimant.
- Was for good cause or due to matters beyond the control of the insurer/plan.
- In the context of a good faith exchange of information with the claimant.
- Not part of a pattern or practice of violations.

Our URA has free telephone language-line services and TTY/TDD for the deaf or hearing impaired. If You or a member You know has difficulty communicating because of an inability to speak or understand English and needs language assistance, call the Customer Experience number on Your ID Card (for the hearing impaired: TTY/TDD 711). Follow the prompts or wait to speak with a Customer Experience Advocate.

XIV. Appeals and Complaints

For the purposes of this section, any reference to "You", "Your" or "Covered Person" also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.

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

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

Blue Cross Blue Shield Global Solutions
Attn: Appeals Department
933 First Avenue
King of Prussia, PA 19406

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

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

GRIEVANCE AND APPEAL PROCEDURES

State Law provides for an internal and independent External Review of grievances. You have the right to file a grievance on any matter pertaining to Your contractual relationship with Us.

No covered person who exercises the right to file a Grievance or Appeal shall be subject to disenrollment or otherwise penalized due to the filing of a grievance or appeal.

All complaint procedures are voluntary and at any time, You, Your health care provider or Your authorized representative, may seek the assistance of the Colorado Division of Insurance, by writing to or calling at the following address:

Mail:	Colorado Division of Insurance Consumer Affairs, Life & Health Section 1560 Broadway, Suite 850 Denver, CO 80202
Telephone:	303-894-7490
Internet:	http://www.dora.state.co.us/insurance

Level 1: Internal Review (Grievance)
If a claim is denied either in whole or in part, You, Your treating Physician or authorized representative, may file a Grievance either orally (by telephone or in person) or in writing within 180 days of receiving a denial in Your claim.

If Your claim was denied due to missing or incomplete information, You, Your treating Physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

You, Your treating Physician or authorized representative, have the right to complain about any decision We make that denies payment on the claim for coverage of a health care service or treatment.

You, Your treating Physician or authorized representative, may request more explanation when Your claim for coverage of a health care service or treatment is denied or was no fully covered.

Contact us when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Cannot find the applicable provision in Your Benefit Plan Document; or
- Disagree with the denial or the amount not covered and You want to appeal.

Your request should contain an explanation of all pertinent issues. To contact Us, You may:

- Send an email to: appeals@bcbsglobalsolutions.com
- Call Us by dialing Our toll free number at: (800) 621-9215
- Write Us at the following address:

  4 Ever Life Insurance Company
  Attn: Appeal Request
  933 First Avenue
  King of Prussia, PA 19406

If Your claim was denied due to missing or incomplete information, You, treating Physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

Within 5 business days of receipt of Your request, You will receive a letter from Us confirming the receipt of Your grievance with the name, address and telephone number of the person who will be reviewing Your grievance. If all required information is complete, Your grievance will be resolved within 30 days of receipt. If additional information is required, We will send You a letter requesting the information. Your grievance will then be resolved within 20 days of receipt of all requested information.

Level 2: Internal Review (Appeal):

If You are not satisfied with Our decision on Your grievance, You, Your treating Physician or authorized representative, have the right to appeal Our determination to confirm the denial of payment on Your claim for coverage of a health care service or treatment within 180 days of Your receipt of notice of Our Adverse Decision.

Adverse Decision means a determination by Us or a designee review agency, that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment rendered and the payment for the service is therefore denied, reduced or terminated.

You may submit any comments, documents, records or other information without regard to whether those materials were considered in the initial grievance review.

You, Your treating physician or authorized representative, may contact Us by:

- Sending an email to: appeals@bcbsglobalsolutions.com
- Calling Us at Our toll free number: (800) 621-9215
- Writing Us at the following address:

  4 Ever Life Insurance Company
  Attn: Grievance/Appeal Request
  933 First Avenue
  King of Prussia, PA 19406

All Internal Appeals must be sent to Us within 180 days of the date You received Our Adverse Decision. We will provide a fair and full review of Your claim by individuals associated with Us but who were not involved in making the initial denial of Your claim.

You, Your treating Physician or authorized representative, may provide Us with additional information that relates to Your claim or may request copies of information that We have that pertains to Your claim. We will notify You, Your treating Physician or authorized representative of Our decision in writing within 30 days of receiving Your request for appeal. If You do not receive Our decision within 30 days of receiving

Your request for an appeal, You, Your treating Physician or authorized representative, may be entitled to file a request for independent external review.

Expedited Internal Review:

If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an Expedited Internal Review of Our denial either orally or in writing and at the same time, request an Expedited External Review. A decision will be made as expeditiously as possible but no more than 72 hours after Your request was received.

If given information is insufficient, You, Your treating Physician or authorized representative, will be notified in writing of information needed as soon as possible, and no later than 24 hours after receipt. You will be given no less than 48 hours to submit the specified information.

You, Your treating Physician or authorized representative, will be notified of Our decision no later than 48 hours after (1) the receipt of the submitted information; or (2) the end of the 48 hour period given to provide the information, whichever is earlier.

However, an Expedited Internal Review may not be provided for retrospective review decisions.

Independent External Review:

When We have denied Your request for Internal Appeal, failed to respond to your Internal Appeal within the specified time or if You are not satisfied with the Final Adverse Decision, You may have the right to have Our decision reviewed by independent health care professionals, who have no association with Us, if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment rendered, by submitting a request for Independent External Review within 4 months after the receipt of this notice to the Colorado Division of Insurance at:

Mail:	Colorado Division of Insurance Consumer Affairs, Life & Health Section 1560 Broadway, Suite 850 Denver, CO 80202
Telephone:	303-894-7490
Internet:	http://www.dora.state.co.us/insurance

You must exhaust the Internal complaint review process to submit a request for Independent External Review. The process is exhausted when:

- We have denied Your request for Internal Appeal;
- You have completed Our Internal Appeals process;
- You do not receive a timely decision from Us on Your appeal and You have not requested or agreed to the delay;
- Expedited internal appeal is requested, therefore You can request an Expedited External Review at the same time; or
- We have waived the exhaustion requirement.

For standard external review, a decision will be made within 45 days of receiving Your request. If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an Expedited External Review of Our denial. However, an Expedited External Review may not be provided for retrospective review decisions.

If Our denial to provide or pay for the health care services or course of treatment is based on a determination that the service or treatment is Experimental or Investigational, You also may be entitled to file a request for External Review of Our denial. For more details, please review Your Benefit Plan Document, contact Us or Your state insurance department at the addresses provided above.

You, Your treating Physician or authorized representative may, provide additional information that relates to Your claim or may request copies of information that We have that pertains to Your claim. You, Your treating Physician or authorized representative will be notified of the independent review organization's decision in writing within 45 days of receiving Your request. .

The ruling provided by the Commissioner of Insurance from an Independent External Review will be in writing and will be final and binding on You and 4 Ever Life to the same extent that each would have been bound by a judgment entered into an action of law or in equity, and except in the instance of fraud, may preclude You exercising any other right or remedy relating to the adverse determination.

Reconsideration of Our Decision:

If, at any time during the review process, You, Your treating Physician or authorized representative, submits information to Us relevant to Our resolution of Your request for review and for which We had not originally considered, We may reconsider our determination.

If Your request has already been submitted for Independent External Review and We choose to reconsider Our decision, the independent review organization will suspend its review process until Our reconsideration process is completed. In such case, We will notify You of Our decision within 15 days of receiving the new information.

If we decide not to reconsider Our determination upon review of the new information, We will forward that new information to the independent review organization not more than 2 business days of receiving it.

XV. Definitions

Active Service
You will be considered in Active Service:

- on any of the Policyholder's scheduled work days if You are performing the regular duties of Your work on that day either at the Policyholder's place of business or at some location to which You are required to travel for Your Policyholder's business.
- on a day which is not one of Your Policyholder's scheduled work days if You were in Active Service on the preceding scheduled work day.

You will not be excluded from coverage if not in Active Service due to health status.

Acquired Brain Injury
The term 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.

Affiliated Company
A corporation or other business entity affiliated with the Employer through common ownership of stock or assets; or as otherwise defined by the Employer. Can include subsidiaries or the parent company of the Policyholder.

Autism Spectrum Disorder
Means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified. For purposes of the Autism benefit coverage is not subject to dollar limits, deductibles, or coinsurance provisions any less favorable to any other illness covered.

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

Certificate or Certificate of Coverage
This term means this document, the Schedule of Benefits, including Your application for coverage under Our benefit program described in this document.

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

Charges
The term Charges means the actual billed Charges; except when the Provider has contracted directly or indirectly with Us for a different amount.

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

Covered Expense(s)
Covered Expenses are the expenses incurred for covered services. Covered Expenses may be limited by other specific maximums described in this in the Schedule of Benefits, and other sections of this Certificate. Covered Expenses are subject to applicable Deductible, Copayments and Coinsurance that may be imposed as specified in the Schedule of Benefits. For non-Participating Providers, only those parts of a charge that are less than or equal to the Allowed Amount are Covered Expenses. An expense is incurred on the date the Covered Person receives the service or supply.

Covered Person
Covered Person means an eligible Participant and any eligible Dependents enrolled in this Certificate and for which the Covered Person is entitled to receive benefits.

Custodial Care
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 Covered Person to function outside the protected, monitored, or controlled environment. It may involve artificial methods such as feeding tubes, ventilators or catheters.

Examples of Custodial Care include:

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

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 Policy.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of their license. It will also include a Physician operating within the scope of their license when they perform any of the Dental Services described in the policy.

Dependent

Dependents are:

- Your lawful spouse or Domestic Partner; and
- any Child of Yours who is:
  - less than 26 years old, including a newborn.
  - 26 or more years old, unmarried and primarily supported by You and incapable of self-sustaining employment by reason of mental or physical disability which arose while the Child was covered as a Dependent under this Plan, or while covered as a Dependent under a prior Plan with no break in coverage. Proof of the Child's condition and dependence must be submitted to the Plan within 31 days after the date the Child ceases to qualify above. From time to time, but not more frequently than once a year, the Plan may require proof of the continuation of such condition and dependence.

The term Child means a child born to You or a child legally adopted by You or placed with You for adoption. It also includes a stepchild or grandchild if: (i) the grandchild is under the primary care of the Insured Participant; and (ii) the legal guardian of the grandchild.

If You provide Us notice, a Child also includes a Child for whom You must provide health insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits for a Dependent Child will continue until the last day of the calendar month in which the limiting age is reached.

A Child under age 26 may be covered as either a primary Participant or as a Dependent Child. You cannot be covered as a primary Participant while also covered as a Dependent of a Participant.

No one may be considered as a Dependent of more than one Participant.

The term Domestic Partner means the person with whom You:

- Are in an exclusive and committed relationship similar to marriage and have been for at least 12 months as long as You and that person:
  - Are not married to each other or anyone else;
  - Meet the age for marriage in Your home state and are mentally competent to consent to contract;
  - Are not related in a manner that would bar a legal marriage in the state in which You live; and
  - Are not in the relationship solely for the purpose of obtaining benefits coverage;
  - Are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created.

Doula

Is a certified or licensed care-giver in the country of their practice of non-medical support to women and their families during labor and childbirth, and also the postpartum period.

Emergency Medical Condition

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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

Employee
The term Employee means a full-time Employee of the Employer who is currently in Active Service who usually works at least 30 hours a week in the conduct of the Group's business. The term does not include Employees who are temporary or who normally work less than 30 hours a week for the Employer. Sole proprietors, partners and independent contractors are also eligible if they are included as an Employee under the health benefit plan of the Employer. An Employee does not include an Employee who works on a part-time, temporary, seasonal or substitute basis.

Employer
The term Employer means a Group participating under the Policy and all affiliated Employers.

Experimental / Investigational
Experimental / Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the determination as to what is experimental or investigational. Experimental / Investigational does not include the routine medical costs associated with clinical trials.

Group
Group refers to the Employer or entity participating under the Policy which the Insurer has issued.

Group Policy or Policy
Group Policy means the agreement between the Insurer and the Group, any riders, this Certificate, the Schedule of Benefits, the Group Application and any Employee application form of the persons covered under the Policy.

Home Country
Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an eligible Dependent who is a Child is the same as that of the eligible Participant.

Home Health Care Services
Home Health Care Services means those services and supplies from a Provider, approved by Us that is engaged in providing, either directly or through an arrangement, health care or skilled nursing services on an intermittent basis in the patient's home in accordance with an approved Home Health Care treatment Plan.

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

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

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

Hospital
The term Hospital means:

- an institution licensed as a Hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an Inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by registered graduate Nurses;
- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a Provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of mental health and substance abuse or other related Sickness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Hospital Confinement or Confined in a Hospital
A person will be considered Confined in a Hospital if they are:

- A registered bed patient in a Hospital upon the recommendation of a Physician;
- Receiving treatment for mental health and substance abuse services in a Partial Hospitalization program;
- Receiving treatment for mental health and substance abuse services in a mental health or substance abuse residential treatment center.

Infertility
Means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:

- absent or incompetent uterus;
- damaged, blocked or absent fallopian tubes;
- damaged, blocked or absent male reproductive tract;
- damaged, diminished or absent sperm;
- damaged, diminished or absent oocytes;
- damaged, diminished or absent ovarian function;
- endometriosis;
- hereditary genetic disease or condition that would be passed to offspring;
- adhesions;
- uterine fibroids;
- sexual dysfunction impeding intercourse;
- teratogens or idiopathic causes;
- polycystic ovarian syndrome;
- inability to become pregnant or cause pregnancy of unknown etiology;
- two or more pregnancy losses, including ectopic pregnancies;
- uterine congenital anomalies, including those caused by diethylstilbestrol(DES).

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

Injury
The term Injury means an accidental bodily Injury.

Inpatient
An Inpatient Admission means a Covered Persons actual entry into a Hospital, extended care facility, or facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility, or facility Provider and for whom a Bed and Board charge is made; the Inpatient stay shall continue until such time as the Covered Person is actually discharged from the facility.

Insurer
Means 4 Ever Life Insurance Company.

International
Means any country or territory other than the United States of America, the District of Columbia, the U.S. Virgin Islands or Puerto Rico.

Life Threatening
Means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Medically Necessary/Medical Necessity
Medically Necessary covered services and supplies are those determined by the medical director to be:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the Covered Person, Physician or Other Health Care Provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the medical director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

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

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

Ophthalmologist
The term Ophthalmologist means a person practicing ophthalmology within the scope of their license. It will also include a Physician operating within the scope of their license when they perform any of the Vision Care services described in the Policy.

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

Optometrist
The term Optometrist means a person practicing optometry within the scope of their license. It will also include a Physician operating within the scope of their license when they perform any of the Vision Care services described in the Policy.

Outpatient Care (Outpatient)
Outpatient means medical, nursing, counseling or therapeutic treatment provided to a Participant who does not require an overnight stay in a Hospital or other Inpatient Facility.

Participant
An enrolled Employee of the Group. Coverage under this Plan is established in the Participant's name.

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

Participating Provider
The term Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Us or Our designee to provide covered services with regard to a particular Plan under which the Participant is covered.

Pharmacy
The term Pharmacy means a licensed retail Pharmacy, or a home delivery (mail order) Pharmacy.

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

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

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

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

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

Plan
Plan means the set of benefits described in the Certificate of Coverage booklet and in the amendments to this Certificate (if any). This Plan is subject to the terms and conditions of the Policy the Insurer has issued to the Group. If changes are made to the Policy or Plan, an amendment or revised Certificate will be issued to the Group for distribution to each Participant affected by the change.

Policy
Policy is the Group Policy We have issued to the Group.

Policyholder
Policyholder means the Group or Employer, including any subsidiaries, affiliates, divisions, branches or other similar entities, or the trust which the Employer created or participates in.

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

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the Pharmacy & Therapeutics (P&T) Committee. Refer to Section VI Prescription Drug Benefit.

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

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

Provider
Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, certified midwife, Hospital, Skilled Nursing Facility, rehabilitation Hospital, birthing facility, or home health Provider.

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

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

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

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

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

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

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

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

Telemedicine Medical Service
Telemedicine Medical Service means a Health Care Service delivered by a Physician licensed in the jurisdiction where they are located, or a health professional acting under the delegation and supervision of a Physician licensed in the jurisdiction where they are located and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Telehealth Service
Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in the jurisdiction where they are located and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

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

Totally Disabled
With respect to a Participant, an inability by reason of illness, Injury or physical condition to perform the material duties of any occupation for which the Participant is or becomes qualified by reason of experience, education or training or with respect to a covered person other than a Participant, the inability by reason of illness, Injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health. The Totally Disabled person must be under the regular care of a Physician.

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

U.S.
Means the United States of America, including the District of Columbia, the U.S. Virgin Islands and Puerto Rico.

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

You, Your
Means an eligible Participant or eligible Dependent.

4 EVER LIFE INSURANCE COMPANY

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, PA 19406

Oakbrook Terrace, Illinois 60181

Dental Services Rider

The Covered Services under this Rider are classified as Diagnostic and Preventive, Basic, Major, and Orthodontic Services. The lists of Covered Services that relate to each type are outlined in the following pages under Description of Covered Services. These Covered Services are covered once all the following requirements are met. It is important to understand these requirements so You can make the most of Your dental benefits.

Benefits are available for the services described in this Rider that are furnished for a covered dental condition. Such Covered Services must meet all of the following requirements:

- They must be Dentally Necessary (see definition of Dentally Necessary);
- They must be named in this Rider as covered;
- They must be furnished by a licensed Dentist (D.M.D. or D.D.S.) or Denturist. Services may also be provided by a Dental Hygienist under the supervision of a licensed Dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law. (These providers are referred to as Dental Care Providers.); and
- They must not be excluded from coverage under this benefit.

At times We may need to review diagnostic materials such as dental X-rays to determine Your available benefits. These materials will be requested directly from Your Dental Care Provider. If We are unable to obtain necessary materials, the Rider will provide benefits only for those Dental Services We can verify as covered.

While in the United States, this Dental insurance gives You access to Dentists through the United Concordia Advantage Plus Network. Dentists participating in the United Concordia Advantage Plus Network have agreed to limit their charge for a Dental Service to the Maximum Allowed Charge for such Dental Service. Under the United Concordia Advantage Plus Network, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of- pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with United Concordia Advantage Plus Network to limit their charges. You are always free to receive Dental Services from any Dentist.

You do not need any authorization from Us to choose a Dentist.

We and the United Concordia Advantage Plus Network do not provide Dental Services. Whether or not benefits are available for a particular Dental Service, does not mean You should or should not receive the Dental Service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and Dental Services to be performed. After Dental Services have been performed, We will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, We recommend that You:

- identify Yourself as an insured in the United Concordia Advantage Plus Network; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the United Concordia Advantage Plus Network. You can obtain a customized listing of United Concordia Advantage Plus Network In-Network Dentists either by calling 1-855-282- 3517 or by visiting Our website at www.bcbsglobalsolutions.com.

Benefit Amounts

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this Rider.

In-Network
If a Covered Service is performed by an In-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:
- the Deductible; and
- any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network or Outside of the United States
If a Covered Service is performed by an Out-of-Network Dentist, We will base the benefit on the Covered Percentage of the reasonable and customary charge.

Out-of-Network Dentists may charge You more than the reasonable and customary charge. If an Out-of- Network Dentist performs a Covered Service, You will be responsible for paying:
- the Deductible;
- any other part of the reasonable and customary charge for which We do not pay benefits; and
- any amount in excess of the reasonable and customary charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts
The Schedule of Benefits sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of- Network. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

For example, if a Covered Service is received Out-of-Network and We pay $300 in benefits for such Service, $300 will be applied toward both the In-Network and the Out-of-Network Maximum Benefit Amounts applicable to such Service.

Deductible Amount
The Deductible Amounts are shown in the Schedule of Benefits.

The Policy Year Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each year before We will pay benefits for such Covered Services.

We apply amounts used to satisfy the Policy Year Individual Deductibles to the Policy Year Family Deductible. Once the Policy Year Family Deductible is satisfied, no further Policy Year Individual Deductibles are required to be met.

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such Covered Service. The Deductible Amount will be applied based on when Dental insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is “incurred”. When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

Alternate Benefit
If We determine that a Covered Service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly Covered Service if such Covered Service:
- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly Covered Service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly Covered Service; and
- when a partial Denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial Denture which is the less costly Covered Service.

If We pay benefits based upon a less costly Covered Service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the Covered Service that was performed and the less costly Covered Service. This is the case even if the Covered Service is performed by an In-Network Dentist.

Certain comprehensive Dental Services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Rider, these separate steps of one Covered Service are considered to be part of the more comprehensive Covered Service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive Covered Service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these Covered Services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

Benefits for Orthodontic Services Begun Prior to this Dental Insurance
If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Requesting an Estimate of Benefits
An Estimate of Benefits verifies, for the Dental Care Provider and You, Your eligibility and benefits. Because We consider alternative treatment at the time We review the estimate, Our review may result in a lower cost of treatment and additional Covered Services under this benefit. It may also clarify, before Covered Services are rendered, treatment that is not covered in whole or in part. This can protect You from unexpected out-of-pocket expenses.

An Estimate of Benefits is not required in order for You to receive Your Dental benefits. However, We suggest that Your Dental Care Provider submit an estimate to Us for any proposed Dental Services in which You are concerned about Your out-of-pocket expenses.

Our Estimate of Benefits should not be considered a guarantee of payment. Payment of any Covered Service will be based on Your eligibility and benefits available at the time Covered Services are rendered.

Accumulation of Deductibles
Deductibles will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and Outside the United States. All other Rider maximums and Covered Service-specific maximums (dollar and occurrence) will also cross-accumulate.

Limited Access Area
If You live in a Limited Access Area, defined as having no In-Network providers within a driving distance greater than 25 miles from Your primary residence, and You receive covered Dental Services from an Out-of-Network provider, We will pay the same Rider allowances as if You utilized an In-Network provider. It is important to note that You will be responsible for the difference between the billed amount and Our payment. Limited Access does not apply outside of the United States.

If You have any questions about Limited Access Area or You are having problems locating an In-Network provider, please call Our Customer Service are at 1-855-254-5304.

Benefit Amounts/Schedule of Benefits

Maximum Benefit per Covered Person	
• Policy Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services	$1,500
• Orthodontic Lifetime Maximum *Limited to Covered Persons under age 19*	$1,500

Deductibles			
	Outside the United States	**In-Network, Inside the United States**	**Out-of-Network, Inside the United States**
Policy Year Individual Deductible Combined: Applicable to Basic Services and Major Services	$50	$50	$50
Policy Year Family Deductible Combined: Applicable to Basic Services and Major Services	$150	$150	$150
Policy Year Individual Deductible: Orthodontic Services	$0	$0	$0
Note: Deductibles will cross-accumulate across all three tiers. All other Rider maximums and Covered Service-specific maximums (dollar and occurrence) will also cross-accumulate across all three tiers.			

Covered Percentage			
	Outside the United States **Based on Reasonable and Customary Charge**	**In-Network, Inside the United States** **Based on Maximum Allowed Charge**	**Out-of-Network, Inside the United States** **Based on Reasonable and Customary Charge**
Diagnostic and Preventive Services	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Orthodontic Services *Limited to Covered Persons under age 19*	50%	50%	50%

Description of Covered Services

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

Diagnostic and Preventive Services

1. Oral exams are limited to twice every Policy Year less the number of problem-focused examinations received during such period.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a Dentist for diagnosis, are limited to twice every Policy Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or Injury, and the potential need for referral for diagnosis and treatment), are limited to twice every Policy Year.
4. Problem-focused examinations are limited to twice every Calendar Year less the number of oral exams received during such Calendar Year.
5. Bitewing x-rays but not more than 2 sets every Policy Year.
6. Full mouth or panoramic x-rays once every 36 months.
7. Cleaning of teeth (oral prophylaxis) twice every Policy Year.
8. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.
9. Genetic test for susceptibility to oral diseases.
10. Diagnostic casts.
11. Topical fluoride treatment for a Dependent Child under age 19, but not more than twice in 12 months.
12. Sealants or sealant repairs for a Dependent Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth in a lifetime.
13. Space maintainers for a Dependent Child under age 19, once per lifetime per tooth area.
14. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12-month period.
15. Other consultations, but not more than once in a 12-month period.
16. Dental Emergency palliative treatment to relieve tooth pain.

Basic Services

1. Intraoral-periapical x-rays.
2. Dental x-rays except as mentioned elsewhere in this Rider.
3. Protective (sedative) fillings.
4. Initial placement of amalgam fillings.
5. Replacement of an existing amalgam filling, but only if:
   a. at least 24 months have passed since the existing filling was placed; or
   b. a new surface of decay is identified on that tooth.
6. Initial placement of resin fillings.
7. Replacement of an existing resin filling, but only if:
   a. at least 24 months have passed since the existing filling was placed; or
   b. a new surface of decay is identified on that tooth.
8. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
9. Simple extractions.
10. Surgical extractions.
11. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24-month period for the same tooth.
12. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
13. Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any Calendar Year less the number of teeth cleanings received during such Calendar Year.
14. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 60- month period.
15. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 60-month period.
16. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 60-month period.
17. Simple repairs of Cast Restorations but not more than once in a 12-month period.
18. Repair of Dentures but not more than once in a 12-month period.
19. Addition of teeth to fixed and permanent Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such Services.

20. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such Services.
21. Re-cementing of Cast Restorations or Dentures but not more than once in a 12-month period.
22. Repair of implant supported prosthetics but not more than once in a 12-month period.

Major Services

1. Oral surgery except as mentioned elsewhere in this Rider.
2. Pulp capping (excluding final restoration).
3. Pulp therapy.
4. Apexification/recalcification.
5. Therapeutic pulpotomy (excluding final restoration).
6. Prefabricated crown, but no more than one replacement for the same tooth surface within 10 Calendar Years.
7. Tissue Conditioning, but not more than once in a 60-month period.
8. Initial installation of Cast Restorations.
9. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 10 Calendar Years of a prior replacement.
10. Core buildup, but no more than once per tooth in a period of 10-Calendar Years.
11. Labial veneers, but no more than once per tooth in a period of 10-Calendar Years.
12. Post and cores, but no more than once per tooth in a period of 10-Calendar Years.
13. Initial installation of fixed and permanent Denture:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth that are lost.
14. Replacement of a non-Serviceable fixed and permanent Denture if such Denture was installed more than 10 Calendar Years prior to replacement.
15. Initial installation of full or removable Dentures:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth that are lost.
16. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12-months of the installation of the immediate, temporary full Denture.
17. Replacement of a non-Serviceable full or removable Denture if such Denture was installed more than 10 Calendar Years prior to replacement.
18. Adjustments of Dentures:
    a. if at least 6 months have passed since the installation of the existing removable Denture; and
    b. not more than once in any 12-month period.
19. Relinings and rebasings of existing removable Dentures:
    a. if at least 6 months have passed since the installation of the existing removable Denture; and
    b. not more than once in any 36-month period.
20. Cleaning and inspection of a removable appliance twice every Calendar Year.
21. Implant Services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10-Calendar Year period:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth.
22. Repair of implants, but not more than once in a 10-Calendar Year period.
23. Implant supported prosthetics, but no more than once for the same tooth position in a 10-Calendar Year period:
    a. when needed to replace congenitally missing teeth; or
    b. when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance under this Rider.
24. Local chemotherapeutic agents.
25. Injections of therapeutic drugs.
26. Application of desensitizing medicaments where periodontal treatment (including scaling, root planning, and periodontal surgery such as osseous surgery) has been performed.
27. Occlusal guards, for bruxism (grinding) only Limited to 1 every 3 rolling years.
28. Occlusal adjustments, but not more than once in a 12-month period.

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

1. There is spacing between adjacent teeth which interferes with the biting function;
2. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
3. Positioning of the jaws or teeth impair chewing or biting function;
4. On an objective professionally recognized Dental Orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
5. Based on a comparable assessment of items (1) through (4) above, there is an overall orthodontic problem that interferes with the biting function.

You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Rider.

Benefits may include the following:

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

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

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate Service;
4. Retreatment and/or Services for any treatment due to relapse;
5. Inpatient or Outpatient Hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

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

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

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

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

Dental Expenses Not Covered

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

Limited and Non-Covered Services
In addition to the specific limitations stated elsewhere in this Rider, this Rider does not cover:

1. **Benefits That Have Been Exhausted -** Amounts that exceed the maximum benefit for a covered service.
2. **Broken Appointment Charges -** Amounts that are billed for broken or late appointments.
3. **Charges For Records Or Reports -** Separate charges from Providers for supplying records or reports, except those We request for utilization review.
4. **Cosmetic Services**
   a. Treatment of congenital malformations, except when the Covered Person is an eligible Dependent Child; or
   b. Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and after effects thereof. This exclusion does not apply to services and supplies covered under the Orthodontia benefit, if this Rider includes that benefit.

5. **Dental Services Received From a:**
   a. Dental or medical department maintained for employees by or on behalf of an Employer; or
   b. Mutual benefit association, labor union, trustee, or similar person or group.

6. **Dietary Services -** Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.

7. **Experimental Or Investigational Services -** Any service or supply that We determine is Experimental or Investigational on the date it's furnished, and any direct or indirect complications and after effects thereof. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

   If We determine that a service is Experimental or Investigational, and therefore not covered, You may appeal Our decision. Please see the "What If I Have A Question Or An Appeal?" section in this booklet for an explanation of the appeals process.

8. **Extra Or Replacement Items -** Extra Dentures or other appliances, including replacements due to loss or theft.

9. **Facility Charges -** Hospital and ambulatory surgical center care for dental procedures.

10. **Family Members Or Volunteers**
    a. Services or supplies that You furnish to yourself or that are furnished to You by a Provider who lives in Your home or is related to You by blood, marriage, or adoption. Examples of such providers are Your spouse, parent or child.
    b. Services or supplies provided by volunteers.

11. **Home-Use Products -** Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.

12. **Increase Of Vertical Dimension -** Any service to increase or alter the vertical dimension.

13. **Military And War-Related Conditions, Including Illegal Acts -** This includes:
    a. Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto;
    b. A Covered Person's commission of an act of riot or insurrection; or
    c. A Covered Person's commission of a felony or act of terrorism

14. **Multiple Providers -** Services provided by more than one Dental Care Provider for the same dental procedure.

15. **No Charge Or You Do Not Legally Have To Pay**
    a. Services for which no charge is made, or for which none would have been made if this Plan were not in effect; or
    b. Services for which You do not legally have to pay, unless benefits must be provided by law.

16. **Non-Standard Techniques -** Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

17. **Not Covered Under This Rider**
    a. Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that is not covered under this Rider;
    b. Services received or ordered when this Rider is not in effect, or when You are not covered under this Rider (including services and supplies started before Your Effective Date or after the date coverage ends), except for major services and root canals that:
       - Were started after Your Effective Date and before the date Your coverage ended under this Rider; and
       - Were completed within 30 days after the date Your coverage ended under this Rider.

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

       The following are deemed service completion dates:
       - For root canals, it's the date the canal is filled;
       - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the seat date;
       - For partial and complete Dentures, it's the seat or delivery date.

18. **Not Dentally Necessary -** Services that are not Dentally Necessary (see definition of "Dentally Necessary").

19. **Fabrication of athletic mouth guards.**

20. **Gold Foil Restorations**

21. **Orthodontia Services -** Orthodontia, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers are only covered under the Orthodontia benefit, if this Rider includes that benefit. This exclusion does not apply to extractions incidental to orthodontic services.

22. **Oral Surgery** for the following procedures:
    a. Surgical services related to a congenital malformation;
    b. Surgical removal of complete bony impacted teeth;
    c. Excision of tumors or cyst of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for Dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

23. **Orthognathic Surgery (Jaw Augmentation or Reduction) -** Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

24. **Outside The Scope Of A Provider's License Or Certification -** Services or supplies that are outside the scope of the Provider's license or certification, or that are furnished by a Provider that is not licensed or certified by the state in which the services or supplies were received.

25. **Prescription Drugs -** Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

26. **Temporomandibular Joint (TMJ) Disorders -** Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and after effects thereof.

27. **Testing And Treatment Services -** Testing and treatment for mercury sensitivity or that are allergy-related.

Payment of Benefits

To Whom Payable
Dental benefits are assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting Your payment on the charge, it is the Provider's responsibility to reimburse You. Because of Our contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider.

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

When one of Our Participants passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as Our Covered Person and benefit payments for unassigned claims should be made payable to the executor.

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

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

Definitions

The terms listed throughout this section have specific meanings under this Rider. As part of the routine operation of this Rider, We use Our expertise and judgment to apply the terms of the contracts or policies for making decisions in specific benefits, eligibility and claims situations. For example, We use the dental judgment and expertise of dental directors to determine whether claims for benefits meet the definitions below of Dentally Necessary or Experimental/Investigational Services.

This does not prevent You from exercising rights You may have under applicable state or federal law to appeal or bring a civil challenge to any eligibility or claims determinations.

Cast Restoration means an inlay, onlay, or crown

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that We will pay for such Covered Services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, or a Dentist located outside of the United States, the percentage of the reasonable and customary charge that We will pay for such Covered Services after any required Deductible is satisfied.

Covered Service means a Dental Service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the Schedule of Benefits or Dental Insurance sections of this Rider.

Dental Care Provider
A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this Rider are available if professional services are provided by a state-licensed Denturist, a Dental Hygienist under the supervision of a licensed Dentist, or other individual performing within the scope of his or her license or certification, as allowed by law and this Rider's benefits would be payable if the Covered Service were provided by a Dental Care Provider as defined above.

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

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dental Insurance means the coverage provided by the Rider for a Covered Person.

Dental Services are procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technology.

Dentally Necessary
Those Covered Services and supplies that a Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, disease or its symptoms, and that are:

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

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

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such Covered Services are performed; or
- any other person whose Covered Services, according to applicable law, must be treated as a Dentist's Covered Services for purposes of the Rider. Each such person must be licensed, certified, registered or reciprocally agreed to practice dentistry in the jurisdiction where the Covered Services are performed and must act within the scope of those credentials.

Dentures means fixed partial Dentures (bridgework), removable partial Dentures and removable full Dentures.

Denturist means a licensed professional dedicated solely to providing removable full and partial Dentures and other dental prosthetics.

Effective Date
Is the date on which Your coverage under this Rider begins. If You re-enroll in this Rider after a lapse in coverage, the date that the coverage begins again will be Your Effective Date.

Experimental/Investigational Services
Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by Us:

- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and has not been granted such approval on the date the service is provided;
- The service is subject to oversight by an institutional review board;
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management, or treatment of the condition; and
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but is not limited to, reports and articles published in authoritative peer reviewed medical and scientific literature.

Injury means Physical harm caused by a sudden event at a specific time and place. It is independent of Sickness, except for infection of a cut or wound. **Please Note:** An Injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

In-Network Dentist means a Dentist, or professional corporation, professional association, partnership or other entity which has entered into a contract with 4 Ever Life or Our designee to provide Dental Services at pre-determined fees. The Dentists qualifying as In-Network Dentists may change from time to time.

Insurer Means 4 Ever Life Insurance Company.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with Us to accept as payment in full for the Dental Service.

Orthodontia means the branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Out-of-Network Dentist means a Dentist who does not participate as an In-Network Dentist.

Participating Provider
The term Participating Provider means a Dentist, or professional corporation, professional association, partnership or other entity which is entered into a contract with 4 Ever Life or Our designee to provide dental services at pre-determined fees. The providers qualifying as Participating Providers may change from time to time.

Temporomandibular Joint (TMJ) Disorders
TMJ disorders include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

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

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company

PRESIDENT SECRETARY

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, PA 19406

Medical Assistance Rider

We will pay for covered services up to the maximum stated below per Policy Year, unless otherwise stated, for the medical assistance services listed below. The Deductible is not applicable.

Schedule of Benefits

Emergency Medical Transportation	100% of the Actual Cost
Repatriation of Mortal Remains	100% of the Actual Cost
Emergency Family Travel Arrangements	Maximum Benefit up to $5,000

Emergency Medical Evacuation Benefit

If You suffer a Life-Threatening/limb-threatening medical condition, and We, and/or Our designee, determines that adequate medical facilities are not available locally, We, or Our designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Us at the phone number indicated on Your identification card to begin this process.

In making a determination, We, and/or Our designee, will consider the nature of the emergency, Your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of Your evacuation to be considered an emergency and requiring emergency evacuation.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the Hospital, as well as pre-admission arrangements, where possible, at the receiving Hospital.

Repatriation

Following any covered emergency evacuation, We will pay for one of the following:

1. If it is deemed Medically Necessary and appropriate by Our or Our designee's medical director, You will be transferred to Your permanent residence via a one-way economy airfare or;
2. You will be transferred back to Your original work location or the location from which You were evacuated via a one-way economy airfare.

If Your transportation needs to be medically supervised, a qualified medical attendant will escort You. Additionally, if We and/or Our designee determine a mode of transport other than economy class seating on a commercial aircraft is required, We or Our designee will arrange accordingly and such will be covered by Us.

Return of Dependent Children

If You have minor children who are left unattended as a result of Your Injury, Sickness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to Your Home Country or country of assignment.

The combined benefit for all necessary emergency medical evacuation services is listed above.

Repatriation of Mortal Remains Benefit

If a Covered Person dies while covered under this Rider, We will pay the necessary expenses actually incurred, up to the Maximum Benefit limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to the Covered Person's primary residence. This benefit covers:

- Expenses for embalming or cremating of the remains.
- The minimally necessary casket or air tray required by the transporting airline.
- Domestic and International paperwork fees, including up to 3 copies of a death certificate.
- Transportation of the remains to Your place of residence or place of burial.
- The certified death certificates required by the Home Country or host country to release the remains.

This benefit does not provide coverage for expenses not listed including expenses for urns, caskets, coffins (beyond the minimally necessary casket or air tray required for transportation), burial or funeral expenses.

All transportation arrangements must be made by the most direct and economical route and conveyance possible and many not exceed the usual and customary charges for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We (or Our authorized assistance provider or designee) authorized in writing, or by an authorized electronic or telephonic means, all expenses in advance.

Emergency Family Travel Arrangements Benefit

If We determine that You are expected to require hospitalization in excess of 7 days at the location to which You are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by You. If Your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent Child is hospitalized.

Payment for lodging, meals, ground transportation and other incidentals are the responsibility of the family member or friend.

The benefit maximum for all necessary emergency family travel arrangements is listed above.

General Conditions Applicable to all Emergency Transportation Benefits and Arrangements

All transportation arrangements must be made by the most direct and economical route and conveyance possible and may not exceed the usual and customary charges for similar transportation in the locality where the expense is incurred.

Exclusions for Emergency Medical Evacuation Benefits

No payment will be made for charges for:

1. Any cost or expense not expressly covered by the Rider and not approved in advance and in writing by Us or our designee and/or not arranged by Us or Our designee. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when We or Our designee cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Covered Person.
2. Non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to You;
3. A condition which would allow for treatment at a future date convenient to You and which does not require emergency evacuation or repatriation;
4. Medical care or services scheduled for You or Your Provider's convenience which are not considered an emergency;
5. Expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
6. Services provided for which no charge is normally made;
7. Expenses incurred while serving in the armed forces of another country;
8. Transportation for Your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
9. Service provided other than those indicated in this Rider;
10. For claim payments that are illegal under applicable law.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company

PRESIDENT

SECRETARY