Filing at a Glance

Company:	Association Mutual Health Insurance Company (AMHIC)
Product Name:	Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan
State:	District of Columbia
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001C Any Size Group - Other
Filing Type:	Rate
Date Submitted:	12/10/2013
SERFF Tr Num:	WWWW-129323558
SERFF Status:	Pending Industry Response
State Tr Num:	
State Status:	
Co Tr Num:	AMHIC2014
Implementation Date Requested:	12/31/2013
Author(s):	Olga Samoilova, Cara Jareb
Reviewer(s):	Darniece Shirley (primary), Alula Selassie, Donghan Xu
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *District of Columbia* **Filing Company:** *Association Mutual Health Insurance Company (AMHIC)*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*

Product Name: *Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*

Project Name/Number: */*

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 12/31/2013

State Status Changed:

Created By: Olga Samoilova

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: AMHIC is domiciled in the District of Columbia

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact: 6.682%

Deemer Date:

Submitted By: Olga Samoilova

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

2014 premium rates submission to the District of Columbia Department of Insurance, Securities and Banking on behalf of the Association Mutual Health Insurance Company (AMHIC)

Company and Contact

Filing Contact Information

Olga Samoilova, Consulting Actuary
901 N. Glebe Road
Arlington, VA 22203

olga.samoilova@towerswatson.com
703-258-8054 [Phone]
703-258-8093 [FAX]

Filing Company Information

(This filing was made by a third party - watsonwyattworldwide)

Association Mutual Health Insurance Company (AMHIC)
2300 N Street, NW.
Washington, DC 20037
(703) 760-6957 ext. [Phone]

CoCode:
Group Code:
Group Name:
FEIN Number: 33-1013490

State of Domicile: District of Columbia
Company Type: Association Captive Insurance Company
State ID Number: AS004

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Darniece Shirley	12/31/2013	12/31/2013

Response Letters

Responded By	Created On	Date Submitted

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Actuarial Memorandum	Olga Samoilova	12/11/2013	12/11/2013

State:	*District of Columbia*	**Filing Company:**	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/31/2013
Submitted Date	12/31/2013
Respond By Date	01/21/2014

Dear Olga Samoilova,

Introduction:

Thank you for your recent filing. Please see below for additional information requested to continue review of the rate filing.

Objection 1

- Cover Letter All Filings (Supporting Document)
- Certificate of Authority to File (Supporting Document)
- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)
- District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)
- Consumer Disclosure Form (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)
- AMHIC 2014 Rate Filing, [] (Rate)

Comments: This rate filing will only be reviewed for Large Groups. Small Group policies can only be sold through the DC Health Benefit Exchange beginning January 1, 2014. All Small Group rate filings were to be approved by the District of Columbia prior to the submission of this rate filing. Please remove all references to Small Groups and update the rate filing, as necessary.

Objection 2

Comments: Does the current Rate Review Data Detail reflect both Small and Large Groups? If so, please revise via post-submission update to reflect Large Groups only. The review of this rate filing is for Large Groups only.

Objection 3

- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)

Comments: Please show the number of policyholders by Plan Type (i.e. Active PPO, Retiree PPO, Active Network PPO, etc.)

Objection 4

- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)

Comments: Please justify the 77% increase in medical trend (over 2013) and 27% decrease in prescription drug trend (over 2013) after all plan design changes were taken into account.

Conclusion:

Sincerely,
Darniece Shirley

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 12/11/2013

Comments:

Minor updates to the Actuarial Memorandum related to the plan design changes description. No numerical values have changed.
Please review this updated version and sorry for the inconvenience.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	AMHIC 2014 Rate Filing - Actuarial Memorandum with Attachments - Revised.pdf AMHIC 2013 Certificate of Coverage - PPO.pdf AMHIC 2013 Certificate of Coverage - Network Only.pdf AMHIC 2013 Certificate of Coverage - QHDHP.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*AMHIC 2014 Rate Filing - Actuarial Memorandum with Attachments.pdf* *AMHIC 2013 Certificate of Coverage - PPO.pdf* *AMHIC 2013 Certificate of Coverage - Network Only.pdf* *AMHIC 2013 Certificate of Coverage - QHDHP.pdf*

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	through SERFF
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	4.906%
Effective Date of Last Rate Revision:	01/01/2013
Filing Method of Last Filing:	through SERFF

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Association Mutual Health Insurance Company (AMHIC)	Increase	6.676%	6.682%	$923,000	46	$14,737,000	28.117%	2.315%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:		1,623	478			9		
Policy Holders:		41	33			4		

State: *District of Columbia* **Filing Company:** *Association Mutual Health Insurance Company (AMHIC)*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*

Product Name: *Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*

Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Association Mutual Health Insurance Company (AMHIC)

HHS Issuer Id: 00000

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan			2110

Trend Factors: The trend assumptions used in 2014 rate development are 8.3% medical and 7.6% prescription drug annual trend rate factors.
After adjusting for the large claims, expected reinsurance recoveries, and prescription drug rebates but before any plan design changes the trends are 8.3% for medical and 7.6% for prescription drug. After the plan design changes the trends are 8.5% medical and 8.0% prescription drug.

FORMS:

New Policy Forms:

Affected Forms:

Other Affected Forms: Current form for the product listed above

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual

Member Months: 25,320

Benefit Change: Increase

Percent Change Requested: Min: 2.315 Max: 28.117 Avg: 6.682

PRIOR RATE:

Total Earned Premium: 13,814,000.00

Total Incurred Claims: 11,162,000.00

Annual $: Min: 190.00 Max: 873.00 Avg: 546.00

REQUESTED RATE:

Projected Earned Premium: 14,737,000.00

Projected Incurred Claims: 11,979,000.00

Annual $: Min: 208.00 Max: 931.00 Avg: 582.00

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		AMHIC 2014 Rate Filing		New		AMHIC 2014 Rate Filing - NAIC Transmittal Document.pdf, AMHIC 2014 Rate Filing - PPACA Uniform Compliance Summary.pdf, AMHIC 2014 Rate Filing - Rate Tables.pdf,

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	District of Columbia

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Association Mutual Health Insurance Company (AMHIC)	District of Columbia	Group Accident Health			33-1013490	AS004

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Olga Samoilova 901 N. Glebe Road Arlington, VA 22203	(703) 258-8054	(703) 258-8093	Olga.Samoilova@towerswatson.com

5.	Requested Filing Mode	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	AMHIC2013 - resubmission
7.	☒ New Submission ☐ Resubmission	Previous file # _____
8.	Market	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☒ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	Type of Insurance (TOI)	H16G Group Health – Major Medical
10.	Sub-Type of Insurance (Sub-TOI)	H16G.001C Any Size Group – Other
11.	Submitted Documents	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☒ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☒ Certifications ☒ Actuarial Memorandum ☒ Other **Certificates of Coverage, Plan Design Charts, Group Application Form**

12.	**Filing Submission Date**	**12/10/2013**
13	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description: 2014 premium rate submission**	

2014 premium rates submission to the District of Columbia Department of Insurance, Securities and Banking on behalf of the Association Mutual Health Insurance Company (AMHIC)

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of the District of Columbia

Print Name **Olga Samoilova** Title **Consulting Actuary**

Signature Olga Samoilova Date: **12/10/2013**

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01			☐ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

LH FFA-1

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number			**AMHIC2014**	
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)			**6.682%**	
Overall percentage rate impact for this filing			**6.682%**	
	Document Name: AMHIC 2014 Rate Filing **Description:**	**Affected Form Numbers**		**Previous State Filing Number**
01	**2014 Active PPO premium rate increase of 6.6%. Particular groups' rate increases range from 2.3% to 28.0% depending on each group's demographics change. Average rate increase is 6.8%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
02	**2014 Retiree PPO premium rate increase of 6.6% + $5 PMPM Medicare Crossover fee. Average rate increase is 7.7%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
03	**2014 Active Network Only premium rate increase of 6.6%. Particular groups' rate increases range from 2.4% to 28.1% depending on each group's demographics change. Average rate increase is 5.9%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
04	**2014 Retiree Network Only premium rate increase of 6.6% + $5 PMPM Medicare Crossover fee. Average rate increase is 7.3%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
05	**2014 Active QHDHP premium rate increase of 6.6%. Particular groups' rate increases range from 2.4% to 11.2% depending on each group's demographics change. Average rate increase is 7.0%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
06	**2014 Retiree QHDHP premium rate increase of 6.7%. Average rate increase is 6.7%.**		☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other** _____	

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Association Mutual Health Insurance Company (AMHIC)		WWWW-129323558	PPO/Network Only/QHDHP	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19**	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 16; Network Only: 18; QHDHP: 18			
H16G Group Health - Major Medical	**Eliminate Annual Dollar Limits on Essential Benefits** – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 3; Network Only: 4; QHDHP: 4			
H16G Group Health - Major Medical	**Eliminate Lifetime Dollar Limits on Essential Benefits**	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 3; Network Only: 4; QHDHP: 4			
H16G Group Health - Major Medical	**Prohibit Rescissions –** Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: This is a guaranteed renewable group plan			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Preventive Services –** Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 54; Network Only: 56; QHDHP: 56			
H16G Group Health - Major Medical	**Extends Dependent Coverage for Children Until age 26 –** If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 18; Network Only: 20; QHDHP: 20			
H16G Group Health - Major Medical	**Appeals Process –** Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 80; Network Only: 82; QHDHP: 81			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
H16G Group Health - Major Medical	**Emergency Services** – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 4; Network Only: 5; QHDHP: 6			
H16G Group Health - Major Medical	**Access to Pediatricians** – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No designation of a PCP for a child (or adult) is required			
	Page Number:			
H16G Group Health - Major Medical	**Access to OB/GYNs** – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 2013 Certificates: PPO: 4; Network Only: 5; QHDHP: 6			

Association Mutual Health Insurance Company (AMHIC)
2014 Active Employee PPO, Network Only, and CDHP Monthly Premium Rates
Group Size Adjustments: Small Groups, +2.7% / Large Groups, -2.2%
Active Employee Demographic Adjustments: Minimum, -20% / Low, -4% / Neutral, 0% / High, +4% / Maximum, +25%
Baseline; 6.60% PPO, 6.60% Network Only, and 6.60% CDHP Base Rate Increase

			Small Groups (under 50 employees)					Large Groups (50+ employees)				
	Base Rates	Percent Increase	Minimum** Demgphcs	Low Demgphcs	Neutral Demgphcs	High Demgphcs	Maximum** Demgphcs	Minimum** Demgphcs	Low Demgphcs	Neutral Demgphcs	High Demgphcs	Maximum** Demgphcs
2013 Rates - PPO												
Single	$680		$559	$670	$698	$726	$873	$532	$638	$665	$692	$831
Employee+Child(ren)	$1,155		$949	$1,139	$1,186	$1,234	$1,483	$904	$1,084	$1,130	$1,175	$1,412
Employee+Spouse	$1,262		$1,037	$1,244	$1,296	$1,348	$1,620	$987	$1,185	$1,234	$1,284	$1,543
Family	$1,720		$1,413	$1,696	$1,766	$1,837	$2,208	$1,346	$1,615	$1,682	$1,749	$2,103
2013 Rates - Network Only												
Single	$498		$409	$491	$511	$532	$639	$390	$468	$487	$507	$609
Employee+Child(ren)	$892		$733	$879	$916	$953	$1,145	$698	$837	$872	$907	$1,090
Employee+Spouse	$975		$801	$961	$1,001	$1,041	$1,252	$763	$915	$954	$992	$1,192
Family	$1,327		$1,090	$1,308	$1,363	$1,417	$1,704	$1,038	$1,246	$1,298	$1,350	$1,622
2013 Rates - CDHP												
Single	$418		$343	$412	$429	$446	$537	$327	$392	$409	$425	$511
Employee+Child(ren)	$747		$614	$736	$767	$798	$959	$584	$701	$731	$760	$913
Employee+Spouse	$817		$671	$805	$839	$873	$1,049	$639	$767	$799	$831	$999
Family	$1,112		$914	$1,096	$1,142	$1,188	$1,428	$870	$1,044	$1,088	$1,131	$1,359
2014 Renewal Rates - PPO*												
Single	$725	6.6%	$596	$715	$745	$774	$931	$567	$681	$709	$737	$886
Employee+Child(ren)	$1,231	6.6%	$1,011	$1,214	$1,264	$1,315	$1,580	$963	$1,156	$1,204	$1,252	$1,505
Employee+Spouse	$1,345	6.6%	$1,105	$1,326	$1,381	$1,437	$1,727	$1,052	$1,263	$1,315	$1,368	$1,644
Family	$1,834	6.6%	$1,507	$1,808	$1,884	$1,959	$2,354	$1,435	$1,722	$1,794	$1,865	$2,242
Increase from 2013 to 2014		6.6%	6.6%	6.7%	6.7%	6.6%	6.6%	6.6%	6.7%	6.6%	6.5%	6.6%
2014 Renewal Rates - Network Only												
Single	$531	6.6%	$436	$524	$545	$567	$682	$415	$499	$519	$540	$649
Employee+Child(ren)	$951	6.6%	$781	$938	$977	$1,016	$1,221	$744	$893	$930	$967	$1,163
Employee+Spouse	$1,039	6.6%	$854	$1,024	$1,067	$1,110	$1,334	$813	$975	$1,016	$1,057	$1,270
Family	$1,415	6.6%	$1,163	$1,395	$1,453	$1,511	$1,817	$1,107	$1,329	$1,384	$1,439	$1,730
Increase from 2013 to 2014		6.6%	6.6%	6.7%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%	6.6%
2014 Renewal Rates - CDHP												
Single	$446	6.7%	$366	$440	$458	$476	$573	$349	$419	$436	$454	$545
Employee+Child(ren)	$796	6.6%	$654	$785	$817	$850	$1,022	$623	$747	$778	$810	$973
Employee+Spouse	$871	6.6%	$716	$859	$895	$930	$1,118	$681	$818	$852	$886	$1,065
Family	$1,185	6.6%	$974	$1,168	$1,217	$1,266	$1,521	$927	$1,113	$1,159	$1,205	$1,449
Increase from 2013 to 2014		6.6%	6.7%	6.7%	6.7%	6.6%	6.6%	6.6%	6.7%	6.6%	6.7%	6.6%

Association Mutual Health Insurance Company (AMHIC)
2014 Retiree PPO, Network Only, and CDHP Monthly Premium Rates
Retiree Rates (Not Adjusted for Demographics)
Baseline; 6.60% PPO, 6.60% Network Only, and 6.60% CDHP Base Rate Increase

2013 Retiree Rates	**PPO**	**Network Only**	**CDHP**
Retiree	$680	$575	$418
Retiree + Child(ren)	$1,040	$882	$638
Retiree + Spouse	$1,360	$1,150	$836
Retiree + Medicare Spouse	$989	$865	$608
Retiree + Family	$1,720	$1,457	$1,056
Retiree + Medicare Spouse + Family	$1,349	$1,172	$828
Medicare Retiree	$309	$290	$190
Medicare Retiree + Child(ren)	$669	$597	$410
Medicare Retiree + Spouse	$989	$865	$608
Medicare Retiree + Medicare Spouse	$618	$580	$380
Medicare Retiree + Family	$1,349	$1,172	$828
Medicare Retiree + Medicare Spouse + Family	$978	$887	$600

2014 Retiree Rates	**PPO**		**Network Only**		**CDHP**	
Retiree	$725	6.6%	$613	6.6%	$446	6.7%
Retiree + Child(ren)	$1,109	6.6%	$940	6.6%	$680	6.6%
Retiree + Spouse	$1,450	6.6%	$1,226	6.6%	$892	6.7%
Retiree + Medicare Spouse	$1,059	7.1%	$927	7.2%	$654	7.6%
Retiree + Family	$1,834	6.6%	$1,553	6.6%	$1,126	6.6%
Retiree + Medicare Spouse + Family	$1,443	7.0%	$1,254	7.0%	$888	7.2%
Medicare Retiree	$334	8.1%	$314	8.3%	$208	9.5%
Medicare Retiree + Child(ren)	$718	7.3%	$641	7.4%	$442	7.8%
Medicare Retiree + Spouse	$1,059	7.1%	$927	7.2%	$654	7.6%
Medicare Retiree + Medicare Spouse	$668	8.1%	$628	8.3%	$416	9.5%
Medicare Retiree + Family	$1,443	7.0%	$1,254	7.0%	$888	7.2%
Medicare Retiree + Medicare Spouse + Family	$1,052	7.6%	$955	7.7%	$650	8.3%

Notes:

* Rates on these exhibits include administrative costs and plan design changes as described in the Benefit Summary exhibit.

** Minimum and Maximum rate categories only apply to new groups that joined in 2006 or after. Groups with 200 or more lives will be experience rated, in order to determine which of the rate categories above they will fall into.

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter All Filings
Comments:	
Attachment(s):	AMHIC 2014 Rate Filing - Cover Letter.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	Certificate of Authority to file the rates on behalf of AMHIC issued to Towers Watson (formerly Watson Wyatt) was submitted with 2008 rates filing and remains in effect
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	AMHIC 2014 Rate Filing - Actuarial Memorandum with Attachments - Revised.pdf AMHIC 2013 Certificate of Coverage - PPO.pdf AMHIC 2013 Certificate of Coverage - Network Only.pdf AMHIC 2013 Certificate of Coverage - QHDHP.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Justification
Bypass Reason:	This is an annual rate revision filing for an existing form
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	This is not a P&C filing
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	This is not a P&C filing

SERFF Tracking #:	*WWWW-129323558*	***State Tracking #:***		***Company Tracking #:***	*AMHIC2014*

State:	*District of Columbia*	***Filing Company:***	*Association Mutual Health Insurance Company (AMHIC)*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan*		
Project Name/Number:	*/*		

Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	2014 rate increase is below the “subject to review” threshold under the Rate Review Regulation
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	Actuarial Memorandum is submitted above under the Actuarial Memorandum section
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	AMHIC's 2014 plan year begins December 31, 2013, 11:59 p.m. and as such is not subject to this requirement
Attachment(s):	
Item Status:	
Status Date:	

TOWERS WATSON

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December 10, 2013

Chester A. McPherson, Interim Commissioner
DC Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

RE: AMHIC 2014 Premium Rate Filing (Company Filing Tracking Number: AMHIC2014)

Dear Sir:

In 2013 Towers Watson was retained by the Board of Directors of Association Mutual Health Insurance Company (AMHIC) to provide actuarial services, including the submission of this 2014 premium rate filing to the Department of Insurance, Securities and Banking.

Following is the information pertinent to the nature of the purpose of the filing:

- Rates effective dates: December 31, 2013, 11:59 p.m. – December 31, 2014, 11:58 p.m.
- Type of product: Self-insured triple option (PPO/Network Only/Qualified HDHP) group health Hospital/Surgical/Medical Expense with Prescription Drug
- Projected group size: 46 participating groups with 1,332 employees and retirees
- Scope and purpose of filing: Annual rate revision
- PPACA reform compliance status: PPACA-compliant non-grandfathered plan
- Average rate increase: 6.7% (ranging from 2.3% to 28.1 % depending on each group's demographics change)

If you have any questions on this, please do not hesitate to contact me at 703-258-8054.

Sincerely,

Olga Samoilova

Olga Samoilova, ASA, MAAA
Consulting Actuary
Towers Watson
(703)-258-8054
Olga.Samoilova@towerswatson.com

Enclosure

Cc: Rhona Byer, Association Mutual Health Insurance Company
Richard Silberstein, Silberstein Insurance Group
Brian Morehead, Silberstein Insurance Group
Cara Jareb, Towers Watson

Association Mutual Health Insurance Company
(AMHIC)

2014 Premium Rate Filing

Plan Year Beginning
December 31, 2013, 11:59 p.m.

Association Mutual Health Insurance Company

(AMHIC)

2014 Premium Rate Filing

I. Actuarial memorandum:

A. The type of policy is a self-insured triple option plan – PPO/Network Only/ Qualified High Deductible Health Plan (QHDHP) – with benefits described in the Attachment - 1 below. 2013 PPO, Network Only, and QHDHP Certificates of Coverage are attached as separate files. 2014 plan year changes not reflected in the Certificates of Coverage are highlighted in **bold blue** font on the Attachment - 1 and include:

Under the PPO and Network Only options:

- Addition of In-Network Wrap Out-of-Pocket Maximum of $6,350 for Individual / $12,700 for Other coverage. In compliance with PPACA requirements, the Wrap Out-of-Pocket Maximum includes deductible, coinsurance, and medical copays, but excludes Prescription Drug copays.

Under the PPO, Network Only, and QHDHP options:

- Added coverage for clinical trials and other required Essential Health Benefits, as defined by District of Columbia
- In compliance with PPACA requirements, eliminated pre-existing conditions exclusion provision.
- In compliance with PPACA requirements, expanded coverage for tobacco use interventions to include generic prescription and over-the-counter smoking cessation medications with no copay.
- Added 100% coverage for travel and non-travel related vaccination at participating pharmacies through pharmacy program.
- Added Medicare Crossover program for Medicare retirees and dependents for additional cost of $5 PMPM applied to the Medicare retiree rates only.
- Increased specific stop loss deductible from $175,000 to $225,000

Qualified High Deductible Health Plan (QHDHP) option is a federally qualified Health Saving Account (HSA) compatible plan.

B. The policy is guaranteed renewable with rate adjustments for group size, experience, and demographic mix.

C. This is an open block of business.

D. The general marketing method is solicitation via AMHIC's captive manager to affiliated associations.

E. The underwriting includes simple questionnaire to determine the prospective group's eligibility (see Attachment - 2 below) and a group's census file to determine which rate category the group falls into. Prospective new groups with 200 or more employees are assigned to one of the rate categories based on their claim experience, if available.

F. There are no issue age limits.

G. The rates were determined based on the actual incurred claims experience of the plan trended forward to 2014 using the aggregate medical and prescription drug annual trend factors, and actual administrative expenses including stop loss charges. In addition, premium taxes and income taxes are assessed. Premiums along with investment income on assets are projected to cover all expenses. Gains are released via dividends or reduced premiums in the coming year.

H. There were no rate development methodology changes for 2014 rates.

I. – L. Not applicable.

M. The projected average annual per capita premium in 2014 is $11,064. This represents a 6.7% increase over what the 2014 average per capita premium would be if the 2013 rates remained in effect ($10,371.) The active employee rate increase for each group is also determined based on the group's demographics change and ranges from 2.3% to 28.1%. Retiree rates are not demographic-adjusted and will increase by 6.6% under the PPO, Network Only, and QHDHP options, except that the Medicare rates will increase by additional $5 PMPM due to the Medicare Crossover program implementation.

N. The anticipated 2014 loss ratio is 81.3%, which is calculated by dividing the projected incurred claims by the anticipated gross premium for 2014. The anticipated loss ratio is presumed reasonable.

O. The annual interest rate of 3% was assumed in development of an investment income estimate. This assumption has a minimal impact on proposed rates.

P. The trend assumptions used in 2014 rate development are 8.3% medical and 7.6% prescription drug annual trend rate factors. After adjusting for the large claims, expected reinsurance recoveries, and prescription drug rebates but before any plan design changes the trends are 8.3% for medical and 7.6% for prescription drug. After the plan design changes taken into account, the projected annual trend factors are 8.5% medical and 8.0% prescription drug.

Q. Of 1,332 employees enrolled in the PPO, Network Only, or QHDHP as of August 2013, 254 (or 19.1%) were not participants a year earlier or as of August 2012.

R. Not applicable.

S. I, Olga Samoilova, ASA, MAAA, Consulting Actuary with Towers Watson, certify that to the best of my knowledge and judgment this rate submission is in compliance with the applicable laws and regulations of the District of Columbia and the benefits are reasonable in relation to the premiums.

II. District of Columbia loss ratio analysis.

A. The submitted rates were developed based on the medical and prescription drug monthly claim lag triangles incurred and paid through July 2013 trended forward to 2014.

B. The average per capita gross premiums earned were $9,372 in 2012, $10,370 in 2013 (projected), and $11,064 in 2014 (projected). The premiums earned net of reinsurance were $8,790 in 2012, $9,638 in 2013 (projected), and $10,185 in 2014 (projected).

C. The average per capita claim cost incurred in 2012 was $7,743 (completed), $8,379 in 2013 (projected), and $8,993 in 2014 (projected).

D. The number of claims information was not considered. The claims data was analyzed in aggregate, which is a generally accepted practice for the medical and prescription drug claims.

E. The loss development factors were determined based on aggregate monthly claim payment patterns.

F. Based on the average gross premium and average incurred claim numbers above, the 2012 loss ratio is 82.6%, the 2013 projected loss ratio is 80.8%, and the 2014 projected loss ratio is 81.3%.

G. Permissible loss ratio (equal to the target gross loss ratio at the time of pricing) was 83.8% in 2012 (reflecting 10.0% expense ratio and 2.2% profit & contingency provision), 81.1% in 2013 (reflecting 11.5% expense ratio and 0% profit & contingency provision), and 81.3% in 2014 (reflecting 12.0% expense ratio and 0% profit & contingency provision). The difference between 100% and the sum of permissible loss ratio, expense ratio, and profit margin is due to the reinsurance premiums offset and investment income. For the purpose of the above calculations expenses include administrative costs and premium and income taxes. Net premiums along with investment income on assets are projected to cover all claims with no projected gain or loss. The implicit contingency provision was used in the form of somewhat conservative trend factors in the incurred claim projection development.

H. As of August 2013 1,332 employees and retirees in the District of Columbia were enrolled in the PPO, Network Only, and QHDHP plans, which is deemed fully credible group size for the purpose of the medical rate development.

I. A 6.7% overall rate change was determined by setting the 2014 projected premiums along with investment income on assets equal to claims and expenses.

III. District of Columbia experience.

A. The total gross premiums earned were $12,699,062 in 2012, $13,753,000 in 2013 (projected), and $14,737,000 in 2014 (projected). The premiums earned net of reinsurance were $11,910,385 in 2012, $12,782,000 in 2013 (projected), and $13,567,000 in 2014 (projected).

B. 1,332 employees from 46 employer groups were enrolled in the PPO, Network Only, and QHDHP options as of August 2013.

C. In 2012 the average rate increase was (3.4%) ranging from (9.5%) to 14% under the PPO and from (4.8%) to 20% under the Network Only plan based on the group's demographics change. In 2013 the average rate increase was 4.9% under the PPO, Network Only, and QHDHP plans with groups' demographics rate categories frozen at 2012 values. In 2014 the average rate increase is 6.7% ranging from 2.3% to 28.1% under the PPO, Network Only, and QHDHP plans based on the group's demographics change.

IV. Rate tables – attached as a separate file.

Q:\AMHIC\2013\Actuarial Rate Filing\Draft Versions and Supporting Data\AMHIC 2014 Rate Filing.docx

Appendix

Association Mutual Health Insurance Company (AMHIC)
2014 Self-Insured Plans Projected Premium Allocation

GROSS PREMIUM	**$14,737,000**	
EXPENSES		
Incurred Claims	$11,979,000	81.3%
Investment Income	($188,000)	-1.3%
Reinsurance Premium	$1,170,000	7.9%
Administrative Costs		
Third Party Administrator / Network Fees	$678,000	4.6%
Office / Staff	$345,000	2.3%
Consulting / Actuarial	$307,000	2.1%
Legal / Accounting / Audit Fees	$178,000	1.2%
PPACA Fees	$143,000	1.0%
Liability Insurance	$45,000	0.3%
Other	$43,000	0.3%
Commissions	$0,000	0.0%
Contingency / Profit	$0,000	0.0%
Premium Taxes	$37,000	0.3%
Income Taxes	$0,000	0.0%
Total Expenses	**$14,737,000**	**100%**

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO Health Benefit Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR DEDUCTIBLE		
Individual	$200	$300
Individual and 1 Dependent	$400	$600
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)	$900 (No more than $300 per Individual can be applied toward the Family Deductible)
Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		
CALENDAR YEAR COINSURANCE MAXIMUM		
Individual	$1,000	$2,000
Individual and 1 Dependent	$2,000	$4,000
Family (Employee and 2 or more Dependents)	$3,000	$6,000
The **Coinsurance** Maximum is the **maximum** amount **of Coinsurance** the Member is responsible for paying for Covered Services **during the Calendar Year**. Eligible **Coinsurance** expenses will be applied to both the In-Network and Out-of-Network **Coinsurance** Maximums. The following do not count towards the **Coinsurance** Maximum: **prescription drugs**, Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	**$6,350**	**N/A**
Individual and 1 Dependent	**$12,700**	**N/A**
Family (Employee and 2 or more Dependents)	**$12,700**	**N/A**
The Out-of-Pocket Maximum is the maximum amount the Member is responsible for paying for Covered Services during the Calendar Year. This includes your payments applied to In-Network Deductible, Coinsurance, and Copayment for eligible medical expenses. The following do not count towards the Out-of-Pocket Maximum: prescription drugs, pre-certification penalties, expenses for non-Covered Services, expenses for out-of-network services, and charges in excess of the Allowed Benefit. Medical Copays will not continue to apply once the Out-of-Pocket Maximum has been met.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient * - includes room, board and ancillary services	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Newborn	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	$50 Copay, then 100% Copay waived if admitted	$50 Copay, then 100% Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician hospital visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit – Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician office visit - Specialist	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Second Surgical Opinion	100% of Allowed Benefit	100% of Allowed Benefit
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy shots/serum (if billed separately from office visit)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	 $20 Copay, then 100% of Allowed Benefit $30 Copay, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulance	70% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Clinical Trials (Patient Costs)	**Covered according to place of service**	**Covered according to place of service**
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education – (includes diabetes Management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	100% of Allowed Benefit	100% of Allowed Benefit
Private Duty Nursing	70% of Allowed Benefit After Deductible	
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Physical	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	$35 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Related Services		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Birthing Center	100% of Allowed Benefit	100% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	PCP – $20 Copay per visit , then 100% of Allowed Benefit Specialist – $30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
PREVENTIVE CARE		
Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Nutritional Counseling	**100%** of Allowed Benefit	**70%** of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Drugs	$30 Copay	$60 Copay
Non-formulary Brand Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Copay**	
**** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Copay**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

Network Only Health Benefit Plan
Summary of Benefits

Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers).

Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.

Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.

INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

CALENDAR YEAR DEDUCTIBLE	
Individual	$200
Individual and 1 Dependent	$400
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)
The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	
CALENDAR YEAR COINSURANCE MAXIMUM	
Individual	$2,000
Individual and 1 Dependent	$4,000
Family (Employee and 2 or more Dependents)	$6,000
The **Coinsurance** Maximum is the **maximum** amount **of Coinsurance** the Member is responsible for paying for Covered Services **during the Calendar Year**. Eligible **Coinsurance** expenses will be applied to both the In-Network and Out-of-Network **Coinsurance** Maximums. The following do not count towards the **Coinsurance** Maximum: **prescription drugs**, Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	
Individual	**$6,350**
Individual and 1 Dependent	**$12,700**
Family (Employee and 2 or more Dependents)	**$12,700**
The Out-of-Pocket Maximum is the maximum amount the Member is responsible for paying for Covered Services during the Calendar Year. This includes your payments applied to Deductible, Coinsurance, and Copayment for eligible medical expenses. The following do not count towards the Out-of-Pocket Maximum: prescription drugs, pre-certification penalties, expenses for non-Covered Services, expenses for out-of-network services, and charges in excess of the Allowed Benefit. Medical Copays will not continue to apply once the Out-of-Pocket Maximum has been met.	

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient * - includes room, board and ancillary services	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Newborn	$200 Copay per admission, then 100% of Allowed Benefit	Not Covered
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	80% of Allowed Benefit * After Deductible	Not Covered
Rehabilitation Facility*	80% of Allowed Benefit * After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Outpatient – includes all services billed by the Hospital	80% of Allowed Benefit After Deductible	Not Covered
Ambulatory Surgical Facility	80% of Allowed Benefit After Deductible	Not Covered
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Physician hospital visit	80% of Allowed Benefit After Deductible	Not Covered
Physician office visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered
Physician office visit - Specialist	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Second Surgical Opinion	80% of Allowed Benefit After Deductible	Not Covered
Surgery (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Allergy shots/serum (if billed separately from office visit)	80% of Allowed Benefit After Deductible	Not Covered
Allergy Testing - Primary Care Physician - Specialist	 $25 Copay, then 100% of Allowed Benefit $35 Copay, then 100% of Allowed Benefit	Not Covered
Ambulance	$75 Copay, then 100% of Allowed Benefit	
Cardiac Rehabilitation	80% of Allowed Benefit After Deductible	Not Covered
Chiropractic Care (maximum of $2,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Clinical Trials (Patient Costs)	**Covered according to place of service**	**Not Covered**
Durable Medical Equipment	80% of Allowed Benefit After Deductible	Not Covered
Home Health Care (maximum of 100 visits per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Home Infusion Therapy	80% of Allowed Benefit After Deductible	Not Covered
Hospice Care (maximum of 180 days per Lifetime)	100 of Allowed Benefit %	Not Covered
Infertility Testing (maximum of $1,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Orthopedic Appliance	80% of Allowed Benefit After Deductible	Not Covered
Patient Education – (includes diabetes Management and ostomy care)	80% of Allowed Benefit After Deductible	Not Covered
Pre-Admission Testing	80% of Allowed Benefit After Deductible	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	80% of Allowed Benefit After Deductible	Not Covered
Renal Dialysis	80% of Allowed Benefit After Deductible	Not Covered
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	80% of Allowed Benefit After Deductible	Not Covered
Urgent Care Center	$50 Copay, then 100% of Allowed Benefit	Not Covered
All Other Eligible Expenses	80% of Allowed Benefit After Deductible	Not Covered

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Maternity Related Services		
Inpatient Hospital*	$200 Copay per admission, then 100% of Allowed Benefit *	Not Covered
Birthing Center	80% of Allowed Benefit After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Physician's Charges for Delivery	80% of Allowed Benefit After Deductible	Not Covered
Pre or post natal office visits (not billed with delivery)	PCP – $25 Copay per visit then 100% of Allowed Benefit Specialist – $35 Copay per visit then 100% of Allowed Benefit	Not Covered
Laboratory tests, x-rays, diagnostic tests, specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	Not Covered
Organ Transplants		
Inpatient Hospital*	80% of Allowed Benefit * After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Transplant Procedure (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow, peripheral stem cell)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays, diagnostic tests	100% of Allowed Benefit After Deductible	Not Covered
PREVENTIVE CARE		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	Not Covered
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	Not Covered
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Nutritional Counseling	**100% of Allowed Benefit**	**Not Covered**

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	$200 Copay per admission, then 100% of Allowed Benefit *	Not Covered
Inpatient Physician Visits	80% of Allowed Benefit After Deductible	Not Covered
Outpatient	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Drugs	$35 Copay	$70 Copay
Non-formulary Brand Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Copay**	
****** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Copay**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		
Over-the-Counter Option		
Non-sedating antihistamines and Prilosec (Please refer to Notes 6 and 7 below)	$10 Copay	

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services and are not covered expenses. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. Guidelines for Non-Sedating Antihistamines – Non-sedating antihistamines may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for all over-the-counter non-sedating antihistamines at the Generic Copay. Examples include Claritin, Allegra, Clarinex and Zyrtec. Keep in mind that in order for the OTC drug to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

7. Guidelines for Prilosec – Prilosec may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

- Over-the-Counter – Benefits are provided for all over-the-counter Prilosec at the Generic Copay. Keep in mind that in order for the OTC Prilosec to be covered, you must have a prescription from your Physician.
- Pharmacist-dispensed Prescriptions – Benefits are not provided for Prilosec when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

8. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

9. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

Qualified High Deductible Health Plan
Summary of Benefits

Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers).

Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the Calendar Year Deductible and pre-certification requirement, as indicated.

Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.

INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One Surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,500	
Individual and 1 Dependent	$3,000	
Family (Employee and 2 or more Dependents)	$3,000	
Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except In-Network ***Preventive Services*** and Preventive Services Drugs, apply to the Deductible. Individual Deductible – This Deductible must be met once each calendar year and applies to Covered Services indicated in this Summary of Benefits. Individual and 1 Dependent Deductible / Family Deductible – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$2,000	$3,000
Individual and 1 Dependent	$4,000	$5,000
Family (Employee and 2 or more Dependents)	$6,000	$7,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit. Individual Out-of-Pocket Maximum – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of Allowed Benefit of the Allowed Benefit for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply. Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of Allowed Benefit of the Allowed Benefit for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Newborn	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician hospital visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Second Surgical Opinion	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy shots/serum (if billed separately from office visit)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulance	90% of Allowed Benefit After deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Clinical Trials (Patient Costs)	**90%** of Allowed Benefit After Deductible	**70%** of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education – (includes diabetes Management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Birthing Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre or post natal office visits (not billed with delivery)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Preventive Care		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Nutritional Counseling	**100%** of Allowed Benefit	**70%** of Allowed Benefit After Deductible
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Drugs	90% After Deductible	90% After Deductible
Non-formulary Brand Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Charge**	
****** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Charge**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The charge for the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

Association Mutual Health Insurance Company
Request for Quote and Group Application

SECTION I:

Part A: Employer Contact Information

1. Employer (full legal name) _____
   _____
2. Main Address _____
   _____
3. Contact Name _____
4. Contact Title _____
5. Contact E-mail _____
6. Telephone Number _____
7. Fax Number _____
8. Website Address _____
9. Proposed Effective Date _____

Part B: Eligibility and Enrollment

10. Do you have at least five active employees? __Yes__No
    If so, what is the expected enrollment in the medical plan? _____
11. Do you have at least 75% of all benefit-eligible employees enrolled in a medical plan?
    __Yes__No
12. Please attach a copy of the IRS Determination Letter that indicates your status as a Non-Profit organization.
13. Please attach a written narrative describing how one of your organization's missions is to support education, research and/or public service.
14. Please attach a census report.
15. Please attach a copy of your most recent medical (and dental) bill and summary of benefits.

SECTION II: Proposed Choice of Coverage

Choice of Health Coverage:
- ☐ PPO Health Plan
- ☐ Kaiser Permanente Select HMO Plan
- ☐ Network Only Health Plan
- ☐ Qualified High Deductible Health Plan

Choice of Other Insurance:
- Dental (Choose one): ☐ Premium ☐ Standard
- ☐ Employee Assistance Plan (must be 100% employer paid)
- ☐ Legal Assistance
- ☐ United Healthcare Vision

☐ Flexible Spending Account ☐ Health Savings Account

☐ Life Insurance

Select One:

☐ 1x annual salary ☐ 1.5x annual salary

☐ 2x annual salary ☐ $50,000 (fixed amount)

SECTION III: Current Plan Information

1. Name of current health insurance carrier: _____

2. Name of current dental insurance carrier: _____

3. Name of current vision insurance carrier: _____

3. Current Plan Details

Health Insurance

Do you contribute at least 75% of the monthly employee only premium for the least expensive medical plan you offer?

__Yes __No

	Employee	Employee/Child	Employee/Spouse	Family
Plan I				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$
Plan II (if applicable)				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$
Plan III (if applicable)				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$

Dental Insurance

Do you contribute at least 50% of the monthly employee dental premium? __Yes __No

	Employee	Employee/Child	Employee/Spouse	Family
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$

Number of COBRA Participants _____

Number of Disabled Employees on the medical plan _____

Is coverage offered to retirees? __Yes __ No If so, please provide a copy of your post-retirement health policy.
# of Retirees _____

4. What other forms of health and welfare plans are available to your employees?

SECTION IV: Underwriting

1. To the best of your information and belief, is there any eligible person who has been treated for:

____ Birth Defects or Disorders	____ Existing Pregnancy
____ Cancer	____ Psychiatric Disorders
____ Chronic Heart, Kidney or Liver Disease	____ Substance Abuse

2. To the best of your information and belief, is there any eligible person who has incurred $10,000 or more in medical expenses in the last 12 months or expects to be hospitalized for a serious medical condition? __Yes __No

3. To the best of your information and belief, is there any eligible person to be enrolled for group coverage who has been denied coverage by your current or last health care carrier? __Yes __No

4. Has the company changed health carriers three (3) times in the past five (5) years? __Yes __No

5. Has the company's coverage been cancelled or is it in the process of being cancelled by the company's current carrier? __Yes __ No

6. Has the company filed for or is in the process of filing for bankruptcy? __Yes __No

SECTION V: Request for Quotation:

I declare that the information given on this application is true and complete to the best of my knowledge and belief.

My organization hereby requests approval to participate in the Employee Benefit Plans(s) offered by AMHIC/SBPA as stated in Section II.

_____

Printed Name Date

_____

Authorized Signature Title

Association Mutual Health Insurance Company

PPO Health Benefit Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) PPO Health Benefit Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, hospice care, and private-duty nursing.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO
HEALTH BENEFIT PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is a preferred provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC PPO Heath Benefit Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC PPO Health Benefit Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductible, Copays, and Coinsurance

The AMHIC PPO Health Benefit Plan is a preferred provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use Network Providers. When you obtain services from a Non-Network Provider, you will usually receive a lower level of benefits (with a few exceptions as outlined in *Section 2 - Summary of Benefits*). If this is the case, your out-of-pocket costs will be more.

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible, Copay and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2
SUMMARY OF BENEFITS

PPO Health Benefit Plan Summary of Benefits		
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.		
Pre-Certification Requirement - The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.		
INDIVIDUAL LIFETIME MAXIMUMS		
Overall Medical Maximum	Unlimited	
Hospice Care	180 days	
Surgery required as the result of Morbid Obesity*	One surgery	
INDIVIDUAL CALENDAR YEAR MAXIMUMS		
Acupuncture	$2,000	
Chiropractic Care	$2,000	
Home Health Care	100 visits	
Infertility Testing	$1,000	
Skilled Nursing/Extended Care Facility	100 days	
	Network Provider (In-Network)	**Non-Network Provider (Out-of-Network)**
CALENDAR YEAR DEDUCTIBLE		
Individual	$200	$300
Individual and 1 Dependent	$400	$600
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)	$900 (No more than $300 per Individual can be applied toward the Family Deductible)
Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$1,000	$2,000
Individual and 1 Dependent	$2,000	$4,000
Family (Employee and 2 or more Dependents)	$3,000	$6,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Newborn	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	$50 Copay, then 100% Copay waived if admitted	$50 Copay, then 100% Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Hospital Visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician Office Visit - Specialist	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Second Surgical Opinion	100% of Allowed Benefit	100% of Allowed Benefit
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Shots/Serum (if billed separately from office visit)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	 $20 Copay, then 100% of Allowed Benefit $30 Copay, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulance	70% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education (includes diabetes management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	100% of Allowed Benefit	100% of Allowed Benefit
Private Duty Nursing	70% of Allowed Benefit After Deductible	
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Physical	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	$35 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Birthing Center	100% of Allowed Benefit	100% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	PCP – $20 Copay per visit, then 100% of Allowed Benefit Specialist – $30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$30 Copay	$60 Copay
Non-Formulary Brand Name Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Copay is paid and the Deductible has been met.

Copay − A flat dollar amount a Participant must pay to receive a specific service or benefit. *Section 2 - Summary of Benefits* shows the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Host Blue – An on-site Blue Cross and/or Blue Shield Licensee providing benefits for Covered Services to the Participant outside of the CareFirst Administrators local Service Area(s).

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more

(35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife

Birthing Center
Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Certified Registered Nurse Anesthetist
Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;

5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;
6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;
2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

"Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of

coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits* are based on the In-Network benefit level and the Allowed Benefit.

AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when

transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.

2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the

Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;

5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

<u>Hemodialysis</u>

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
    d. Food services or meals other than dietary counseling.
    e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
    f. Private duty nursing.
    g. Services by volunteers or people who do not regularly charge for their services.
    h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care.***

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

    a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
    b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.

3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*

4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.
8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated

marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);
    g. Neuroblastoma Stage III or IV in children;
    h. Homozygous beta thalassemia (thalassemia major);
    i. Hodgkin's lymphoma;
    j. Non-Hodgkin's lymphoma;
    k. Myelodysplastic syndromes;
    l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
    m. Multiple myeloma;
    n. Sickle-cell anemia;
    o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.
12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

Private Duty Nursing

Definition - Services that require the training, judgment, and technical skills of an actively practicing registered nurse (RN) or licensed practical nurse (LPN). Such services must be prescribed by your attending Physician for the continuous medical treatment of your condition.

Medical-Surgical Benefits

Outpatient: We will allow benefits for private duty nursing services in your home or other outpatient location.

Limitations and Exclusions

1. **Alternative Care** — We will not allow benefits for nursing services ordinarily provided by a Hospital staff or its intensive care or coronary care units.
2. **Claims Review** — All claims are subject to review to ensure that private duty nursing services are absolutely required. The fact that private duty nursing services are a benefit under this Certificate does not guarantee that any or all services will be covered.
3. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Family Members** — We will not allow benefits for services provided by a family member, regardless of the circumstances.
5. **Maximum Payment Limits** — Private duty nursing benefits are limited to one eight-hour shift per day.
6. **Physician's Certification** — All claims for private duty nursing services must include a Physician's certification that such services are Medically Necessary. The billing must also indicate the nurse's degree and license number.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.
2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;
    d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
    e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
    f. Deafness;
    g. Disorders of cognitive etiology;
    h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

    a. Artificial arms, legs, or eyes.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Maxillofacial prostheses.
    e. Cervical collars.
    f. Surgical implants.
    g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.
5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.

2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:

    a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
    b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***
7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*

12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Copay amounts are as follows:

PRESCRIPTION DRUG PLAN	Copay per Prescription	
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$30 Copay	$60 Copay
Non-Formulary Brand Name Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services as specified by PPACA**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest Copay.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher Copay.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Copay. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher Copay for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services – Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.
7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an “off-label” use. This can mean that the drug is:

1. used for a different disease or medical condition;

2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
3. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
4. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
5. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
6. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
7. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.

8. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;
    c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
    d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
    e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
    f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
    g. Drugs and supplies unless specifically included as a covered drug;
    h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
    i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

9. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.
10. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
11. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
12. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
13. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
14. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
15. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Copay as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription Copay expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Copay and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Copay. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription Copay. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.
2. **Copay** — The predetermined fixed-dollar or percentage amount that the Participant must pay for each separate prescription or refill of a covered drug.
3. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
4. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay as a Copay for each prescription, with drugs listed on the Formulary typically available at a lower Copay to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
5. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
6. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.

7. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
8. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Copay.
9. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

10. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
11. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
12. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
13. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible, Copay and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission.

Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond

the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a

statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is

incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO. The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the

IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and

(3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the

Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any other person or entity to whom an assignment of benefits has been made by a Participant or

Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

    a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
    b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

    We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the

group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this PPO Health Benefit Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N Byer

Name: Rhona N Byer

Title: Executive Director

Date: 11/7/2013

Association Mutual Health Insurance Company

Network Only Health Benefit Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) Network Only Health Benefit Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, and hospice care.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY
HEALTH BENEFIT PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is an exclusive provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC Network Only Heath Benefit Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC Network Only Health Benefit Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductible, Copays, and Coinsurance

The AMHIC Network Only Health Benefit Plan is an exclusive provider plan. In general, benefits are not provided for services rendered by Non-Network Providers (with a few exceptions as outlined in *Section 2 - Summary of Benefits*).

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible, Copay and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2

SUMMARY OF BENEFITS

Network Only Health Benefit Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-Certification Requirement - The items marked below with an asterisk (*) ***require*** pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days
CALENDAR YEAR DEDUCTIBLE	
Individual	$200
Individual and 1 Dependent	$400
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)
The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	
Individual	$2,000
Individual and 1 Dependent	$4,000
Family (Employee and 2 or more Dependents)	$6,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. The following do not count towards the Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Newborn	$200 Copay per admission, then 100% of Allowed Benefit	Not Covered
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	80% of Allowed Benefit* After Deductible	Not Covered
Rehabilitation Facility*	80% of Allowed Benefit* After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Outpatient – includes all services billed by the Hospital	80% of Allowed Benefit After Deductible	Not Covered
Ambulatory Surgical Facility	80% of Allowed Benefit After Deductible	Not Covered
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Physician Hospital Visit	80% of Allowed Benefit After Deductible	Not Covered
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered
Physician Office Visit - Specialist	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Second Surgical Opinion	80% of Allowed Benefit After Deductible	Not Covered
Surgery (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Allergy Shots/Serum (if billed separately from office visit)	80% of Allowed Benefit After Deductible	Not Covered
Allergy Testing - Primary Care Physician - Specialist	 $25 Copay, then 100% of Allowed Benefit $35 Copay, then 100% of Allowed Benefit	Not Covered
Ambulance	$75 Copay, then 100% of Allowed Benefit	
Cardiac Rehabilitation	80% of Allowed Benefit After Deductible	Not Covered
Chiropractic Care (maximum of $2,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Durable Medical Equipment	80% of Allowed Benefit After Deductible	Not Covered
Home Health Care (maximum of 100 visits per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Home Infusion Therapy	80% of Allowed Benefit After Deductible	Not Covered
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	Not Covered
Infertility Testing (maximum of $1,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Orthopedic Appliance	80% of Allowed Benefit After Deductible	Not Covered
Patient Education (includes diabetes management and ostomy care)	80% of Allowed Benefit After Deductible	Not Covered
Pre-Admission Testing	80% of Allowed Benefit After Deductible	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	80% of Allowed Benefit After Deductible	Not Covered
Renal Dialysis	80% of Allowed Benefit After Deductible	Not Covered
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	80% of Allowed Benefit After Deductible	Not Covered
Urgent Care Center	$50 Copay, then 100% of Allowed Benefit	Not Covered
All Other Eligible Expenses	80% of Allowed Benefit After Deductible	Not Covered

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Birthing Center	80% of Allowed Benefit After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Physician's Charges for Delivery	80% of Allowed Benefit After Deductible	Not Covered
Prenatal or postnatal office visits (not billed with delivery)	PCP – $25 Copay per visit then 100% of Allowed Benefit Specialist – $35 Copay per visit then 100% of Allowed Benefit	Not Covered
Laboratory tests, x-rays, diagnostic tests, specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	Not Covered
Organ Transplants		
Inpatient Hospital*	80% of Allowed Benefit* After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Transplant Procedure	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays, diagnostic tests	100% of Allowed Benefit After Deductible	Not Covered
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	Not Covered
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	Not Covered
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Physician Visits	80% of Allowed Benefit After Deductible	Not Covered
Outpatient	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$35 Copay	$70 Copay
Non-Formulary Brand Name Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		
Over-the-Counter Option		
Non-sedating antihistamines and Prilosec (Please refer to Notes 6 and 7 below)	$10 Copay	

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services and are not covered expenses. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. Guidelines for Non-Sedating Antihistamines – Non-sedating antihistamines may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for all over-the-counter non-sedating antihistamines at the Generic Copay. Examples include Claritin, Allegra, Clarinex and Zyrtec. Keep in mind that in order for the OTC drug to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

7. Guidelines for Prilosec – Prilosec may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for over-the-counter Prilosec at the Generic Copay. Keep in mind that in order for OTC Prilosec to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for Prilosec when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

8. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

9. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Copay is paid and the Deductible has been met.

Copay − A flat dollar amount a Participant must pay to receive a specific service or benefit. *Section 2 - Summary of Benefits* shows the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Host Blue – An on-site Blue Cross and/or Blue Shield Licensee providing benefits for Covered Services to the Participant outside of the CareFirst Administrators local Service Area(s).

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more

(35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife

Birthing Center
Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Certified Registered Nurse Anesthetist
Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;
5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;
6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;

2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

    "Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

    Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the

qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an

Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled

continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits are* based on the In-Network benefit level and the Allowed Benefit.

AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when

transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.

2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the

Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;

5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

<u>Hemodialysis</u>

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
    d. Food services or meals other than dietary counseling.
    e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
    f. Private duty nursing.
    g. Services by volunteers or people who do not regularly charge for their services.
    h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care.***

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

    a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
    b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.

3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*

4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.
8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated

marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);
    g. Neuroblastoma Stage III or IV in children;
    h. Homozygous beta thalassemia (thalassemia major);
    i. Hodgkin's lymphoma;
    j. Non-Hodgkin's lymphoma;
    k. Myelodysplastic syndromes;
    l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
    m. Multiple myeloma;
    n. Sickle-cell anemia;
    o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.
12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.
2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;
    d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
    e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
    f. Deafness;
    g. Disorders of cognitive etiology;
    h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*****.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

a. Artificial arms, legs, or eyes.
b. Leg braces, including attached shoes.
c. Arm and back braces.
d. Maxillofacial prostheses.
e. Cervical collars.
f. Surgical implants.
g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.
5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural

procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:
   a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
   b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***
7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*
12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Copay amounts are as follows:

PRESCRIPTION DRUG PLAN	Copay per Prescription	
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$35 Copay	$70 Copay
Non-Formulary Brand Name Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Over-the-Counter Option	**Retail Pharmacy**	
Non-sedating antihistamines and Prilosec	$10 Copay	

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest Copay.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should

determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher Copay.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Copay. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Over-the-Counter Option - In addition to the prescription drug benefits described above, your Prescription Drug Plan provides benefits for OTC non-sedating antihistamines, when prescribed by a Physician. To be eligible for benefits, you must present your prescription to the Pharmacy when you purchase the drug. You will only be required to pay the Generic Copay. Examples of OTC non-sedating antihistamines include Claritin, Allegra, Clarinex and Zyrtec.

Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

The Prescription Drug Plan also provides benefits for the OTC proton pump inhibitor, Prilosec, when prescribed by a Physician. You will only be required to pay the Generic Copay at the time you purchase OTC Prilosec with a prescription from your Physician.

If you purchase your OTC drug from a Non-Network Pharmacy or do not have your Identification Card with you at the time of purchase, you may submit a claim directly to Express Scripts. To do so, please complete a prescription drug claim form, attach the prescription from the Physician and the receipt you received from the Pharmacy, and send it to Express Scripts. The Prescription Drug Plan will pay the cost of the drug, less the Generic Copay amount.

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher Copay for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the

Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.

7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Antihistamines** – Prescription non-sedating antihistamines dispensed by a pharmacist are not covered. Only OTC non-sedating antihistamines, when prescribed by a Physician, are covered.

3. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
4. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
5. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
6. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
7. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
8. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.
9. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;
    c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
    d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
    e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
    f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
    g. Drugs and supplies unless specifically included as a covered drug;
    h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
    i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

10. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.

11. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
12. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
13. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
14. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
15. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
16. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Copay as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription Copay expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Copay and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Copay. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription Copay. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own

registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.

2. **Copay** — The predetermined fixed-dollar or percentage amount that the Participant must pay for each separate prescription or refill of a covered drug.
3. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
4. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay as a Copay for each prescription, with drugs listed on the Formulary typically available at a lower Copay to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
5. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
6. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.
7. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
8. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Copay.
9. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

10. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
11. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

12. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, “Caution: Federal law prohibits dispensing without a prescription.” Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
13. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible, Copay and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Benefits are not provided for services rendered by Non-Network Providers, other than Medically Necessary ambulance services, Medical Emergencies, and certain exceptions listed in *Section 2 - Summary of Benefits*. Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any

such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman

established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO.

The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant

or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and (3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other

Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any

other person or entity to whom an assignment of benefits has been made by a Participant or Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any

court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
   b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

   We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY HEALTH BENEFIT PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this Network Only Health Benefit Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N. Byer

Name: Rhona N. Byer

Title: Executive Director

Date: 11/7/2013

Association Mutual Health Insurance Company

Qualified High Deductible Health Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) Qualified High Deductible Health Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, and hospice care.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is a preferred provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC Qualified High Deductible Heath Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC Qualified High Deductible Health Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductibles and Coinsurance

The AMHIC Qualified High Deductible Health Plan is a preferred provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use Network Providers. When you obtain services from a Non-Network Provider, you will usually receive a lower level of benefits (with a few exceptions as outlined in *Section 2 - Summary of Benefits*). If this is the case, your out-of-pocket costs will be more.

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductible and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2

SUMMARY OF BENEFITS

Qualified High Deductible Health Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-Certification Requirement - The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,500	
Individual and 1 Dependent	$3,000	
Family (Employee and 2 or more Dependents)	$3,000	
Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except In-Network ***Preventive Services*** and Preventive Services Drugs, apply to the Deductible. Individual Deductible – This Deductible must be met once each calendar year and applies to Covered Services indicated in this Summary of Benefits. Individual and 1 Dependent Deductible / Family Deductible – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$2,000	$3,000
Individual and 1 Dependent	$4,000	$5,000
Family (Employee and 2 or more Dependents)	$6,000	$7,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit. Individual Out-of-Pocket Maximum – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of the Allowed Benefit for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply. Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of the Allowed Benefit for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Newborn	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Hospital Visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Second Surgical Opinion	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Shots/Serum (if billed separately from office visit)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulance	90% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education (includes diabetes management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Birthing Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Non-Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The charge for the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Deductible has been met.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a

drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing,

motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her

unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's

adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Preventive Services Drugs – Preventive Services Drugs include the following drug categories: cardiovascular disease prevention, fracture prevention, prevention of infection, prenatal care, breast cancer prevention, diabetes-related complication prevention, nutritional disorders during childhood prevention, and anti-asthmatic and bronchodilator agents. Preventive Services Drugs also include over-the-counter (OTC) drugs related to Preventive Services and FDA-approved generic drugs and OTC drugs, devices, and supplies related to Women's Preventive Services, in compliance with the Patient Protection and Affordable Act of 2010.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife
Birthing Center	Certified Registered Nurse Anesthetist

Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing

Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;
5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;

6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;
2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

    "Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been

repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in

writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last

day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA

coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits* are based on the In-Network benefit level and the Allowed Benefit.
AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to

ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.
2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.

2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification

request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;
5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

Hemodialysis

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant

with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.

c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
d. Food services or meals other than dietary counseling.
e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
f. Private duty nursing.
g. Services by volunteers or people who do not regularly charge for their services.
h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*.**

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.
3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*****.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please

refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).
3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition

(e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.

8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;

2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);

g. Neuroblastoma Stage III or IV in children;
h. Homozygous beta thalassemia (thalassemia major);
i. Hodgkin's lymphoma;
j. Non-Hodgkin's lymphoma;
k. Myelodysplastic syndromes;
l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
m. Multiple myeloma;
n. Sickle-cell anemia;
o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.

12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.

2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;

d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
f. Deafness;
g. Disorders of cognitive etiology;
h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*****.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.

2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

    a. Artificial arms, legs, or eyes.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Maxillofacial prostheses.
    e. Cervical collars.
    f. Surgical implants.
    g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.

5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*****.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:

    a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
    b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***

7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*
12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Coinsurance amounts are as follows:

PRESCRIPTION DRUG PLAN	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Non-Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest cost.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher cost.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Coinsurance. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher cost for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Coinsurance. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.
7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an “off-label” use. This can mean that the drug is:

1. used for a different disease or medical condition;

2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
3. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
4. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
5. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
6. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
7. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.
8. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;

c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
g. Drugs and supplies unless specifically included as a covered drug;
h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

9. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.
10. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
11. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
12. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
13. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
14. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
15. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Coinsurance as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Coinsurance and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Coinsurance. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes prescription costs. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.
2. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
3. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay for each prescription, with drugs listed on the Formulary typically available at a lower cost to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
4. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
5. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.
6. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
7. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's

Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Coinsurance.

8. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

9. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
10. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
11. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
12. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Coinsurance. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission.

Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any

such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman

established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO.

The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant

or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and (3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other

Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any

other person or entity to whom an assignment of benefits has been made by a Participant or Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any

court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
   b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

   We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this Qualified High Deductible Health Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N Byer

Name: Rhona N Byer

Title: Executive Director

Date: 11/7/2013

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/04/2013		Supporting Document	Actuarial Memorandum	12/11/2013	AMHIC 2014 Rate Filing - Actuarial Memorandum with Attachments.pdf (Superceded) AMHIC 2013 Certificate of Coverage - PPO.pdf (Superceded) AMHIC 2013 Certificate of Coverage - Network Only.pdf (Superceded) AMHIC 2013 Certificate of Coverage - QHDHP.pdf (Superceded)

Association Mutual Health Insurance Company
(AMHIC)

2014 Premium Rate Filing

Plan Year Beginning
December 31, 2013, 11:59 p.m.

Association Mutual Health Insurance Company

(AMHIC)

2014 Premium Rate Filing

I. Actuarial memorandum:

A. The type of policy is a self-insured triple option plan – PPO/Network Only/ Qualified High Deductible Health Plan (QHDHP) – with benefits described in the Attachment - 1 below. 2013 PPO, Network Only, and QHDHP Certificates of Coverage are attached as separate files. 2014 plan year changes not reflected in the Certificates of Coverage are highlighted in **bold blue** font on the Attachment - 1 and include:

Under the PPO and Network Only options:

- Addition of In-Network Wrap Out-of-Pocket Maximum of $6,350 for Individual / $12,700 for Other coverage. In compliance with PPACA requirements, the Wrap Out-of-Pocket Maximum includes deductible, coinsurance, and medical copays, but excludes Prescription Drug copays.

Under the PPO, Network Only, and QHDHP options:

- Added coverage for clinical trials and other required Essential Health Benefits, as defined by District of Columbia
- In compliance with PPACA requirements, expanded coverage for tobacco use interventions to include generic prescription and over-the-counter smoking cessation medications with no copay.
- Added 100% coverage for travel and non-travel related vaccination at participating pharmacies through pharmacy program.
- Added Medicare Crossover program for Medicare retirees and dependents for additional cost of $5 PMPM applied to the Medicare retiree rates only.

Qualified High Deductible Health Plan (QHDHP) option is a federally qualified Health Saving Account (HSA) compatible plan.

B. The policy is guaranteed renewable with rate adjustments for group size, experience, and demographic mix.

C. This is an open block of business.

D. The general marketing method is solicitation via AMHIC's captive manager to affiliated associations.

E. The underwriting includes simple questionnaire to determine the prospective group's eligibility (see Attachment - 2 below) and a group's census file to determine which rate category the group falls into. Prospective new groups with 200 or more employees are assigned to one of the rate categories based on their claim experience, if available.

F. There are no issue age limits.

G. The rates were determined based on the actual incurred claims experience of the plan trended forward to 2014 using the aggregate medical and prescription drug annual trend factors, and actual administrative expenses including stop loss charges. In addition, premium taxes and income taxes are assessed. Premiums along with investment income on assets are projected to cover all expenses. Gains are released via dividends or reduced premiums in the coming year.

H. There were no rate development methodology changes for 2014 rates.

I. – L. Not applicable.

M. The projected average annual per capita premium in 2014 is $11,064. This represents a 6.7% increase over what the 2014 average per capita premium would be if the 2013 rates remained in effect ($10,371.) The active employee rate increase for each group is also determined based on the group's demographics change and ranges from 2.3% to 28.1%. Retiree rates are not demographic-adjusted and will increase by 6.6% under the PPO, Network Only, and QHDHP options, except that the Medicare rates will increase by additional $5 PMPM due to the Medicare Crossover program implementation.

N. The anticipated 2014 loss ratio is 81.3%, which is calculated by dividing the projected incurred claims by the anticipated gross premium for 2014. The anticipated loss ratio is presumed reasonable.

O. The annual interest rate of 3% was assumed in development of an investment income estimate. This assumption has a minimal impact on proposed rates.

P. The trend assumptions used in 2014 rate development are 8.3% medical and 7.6% prescription drug annual trend rate factors. After adjusting for the large claims, expected reinsurance recoveries, and prescription drug rebates but before any plan design changes the trends are 8.3% for medical and 7.6% for prescription drug. After the plan design changes taken into account, the projected annual trend factors are 8.5% medical and 8.0% prescription drug.

Q. Of 1,332 employees enrolled in the PPO, Network Only, or QHDHP as of August 2013, 254 (or 19.1%) were not participants a year earlier or as of August 2012.

R. Not applicable.

S. I, Olga Samoilova, ASA, MAAA, Consulting Actuary with Towers Watson, certify that to the best of my knowledge and judgment this rate submission is in compliance with the applicable laws and regulations of the District of Columbia and the benefits are reasonable in relation to the premiums.

II. District of Columbia loss ratio analysis.

A. The submitted rates were developed based on the medical and prescription drug monthly claim lag triangles incurred and paid through July 2013 trended forward to 2014.

B. The average per capita gross premiums earned were $9,372 in 2012, $10,370 in 2013 (projected), and $11,064 in 2014 (projected). The premiums earned net of reinsurance were $8,790 in 2012, $9,638 in 2013 (projected), and $10,185 in 2014 (projected).

C. The average per capita claim cost incurred in 2012 was $7,743 (completed), $8,379 in 2013 (projected), and $8,993 in 2014 (projected).

D. The number of claims information was not considered. The claims data was analyzed in aggregate, which is a generally accepted practice for the medical and prescription drug claims.

E. The loss development factors were determined based on aggregate monthly claim payment patterns.

F. Based on the average gross premium and average incurred claim numbers above, the 2012 loss ratio is 82.6%, the 2013 projected loss ratio is 80.8%, and the 2014 projected loss ratio is 81.3%.

G. Permissible loss ratio (equal to the target gross loss ratio at the time of pricing) was 83.8% in 2012 (reflecting 10.0% expense ratio and 2.2% profit & contingency provision), 81.1% in 2013 (reflecting 11.5% expense ratio and 0% profit & contingency provision), and 81.3% in 2014 (reflecting 12.0% expense ratio and 0% profit & contingency provision). The difference between 100% and the sum of permissible loss ratio, expense ratio, and profit margin is due to the reinsurance premiums offset and investment income. For the purpose of the above calculations expenses include administrative costs and premium and income taxes. Net premiums along with investment income on assets are projected to cover all claims with no projected gain or loss. The implicit contingency provision was used in the form of somewhat conservative trend factors in the incurred claim projection development.

H. As of August 2013 1,332 employees and retirees in the District of Columbia were enrolled in the PPO, Network Only, and QHDHP plans, which is deemed fully credible group size for the purpose of the medical rate development.

I. A 6.7% overall rate change was determined by setting the 2014 projected premiums along with investment income on assets equal to claims and expenses.

III. District of Columbia experience.

A. The total gross premiums earned were $12,699,062 in 2012, $13,753,000 in 2013 (projected), and $14,737,000 in 2014 (projected). The premiums earned net of reinsurance were $11,910,385 in 2012, $12,782,000 in 2013 (projected), and $13,567,000 in 2014 (projected).

B. 1,332 employees from 46 employer groups were enrolled in the PPO, Network Only, and QHDHP options as of August 2013.

C. In 2012 the average rate increase was (3.4%) ranging from (9.5%) to 14% under the PPO and from (4.8%) to 20% under the Network Only plan based on the group's demographics change. In 2013 the average rate increase was 4.9% under the PPO, Network Only, and QHDHP plans with groups' demographics rate categories frozen at 2012 values. In 2014 the average rate increase is 6.7% ranging from 2.3% to 28.1% under the PPO, Network Only, and QHDHP plans based on the group's demographics change.

IV. Rate tables – attached as a separate file.

Q:\AMHIC\2013\Actuarial Rate Filing\Draft Versions and Supporting Data\AMHIC 2014 Rate Filing.docx

Appendix

Association Mutual Health Insurance Company (AMHIC)
2014 Self-Insured Plans Projected Premium Allocation

GROSS PREMIUM	**$14,737,000**	
EXPENSES		
Incurred Claims	$11,979,000	81.3%
Investment Income	($188,000)	-1.3%
Reinsurance Premium	$1,170,000	7.9%
Administrative Costs		
Third Party Administrator / Network Fees	$678,000	4.6%
Office / Staff	$345,000	2.3%
Consulting / Actuarial	$307,000	2.1%
Legal / Accounting / Audit Fees	$178,000	1.2%
PPACA Fees	$143,000	1.0%
Liability Insurance	$45,000	0.3%
Other	$43,000	0.3%
Commissions	$0,000	0.0%
Contingency / Profit	$0,000	0.0%
Premium Taxes	$37,000	0.3%
Income Taxes	$0,000	0.0%
Total Expenses	**$14,737,000**	**100%**

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO Health Benefit Plan
Summary of Benefits

Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers).
Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.

Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.

INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

	Network Provider (In-Network)	**Non-Network Provider (Out-of-Network)**
CALENDAR YEAR DEDUCTIBLE		
Individual	$200	$300
Individual and 1 Dependent	$400	$600
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)	$900 (No more than $300 per Individual can be applied toward the Family Deductible)

Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.

CALENDAR YEAR COINSURANCE OUT-OF-POCKET MAXIMUM		
Individual	$1,000	$2,000
Individual and 1 Dependent	$2,000	$4,000
Family (Employee and 2 or more Dependents)	$3,000	$6,000

The **Coinsurance** Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network **Coinsurance** Out-of- Pocket Maximums. The following do not count towards the **Coinsurance** Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR WRAP OUT-OF-POCKET MAXIMUM		
Individual	**$6,350**	**Unlimited**
Individual and 1 Dependent	**$12,700**	**Unlimited**
Family (Employee and 2 or more Dependents)	**$12,700**	**Unlimited**
The Wrap Out-of-Pocket Maximum is the total amount the Member is responsible for paying for a Covered Service, including Deductible, Coinsurance, and medical Copays. The following do not count towards the Wrap Out-of-Pocket Maximum: prescription drug Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient * - includes room, board and ancillary services	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Newborn	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	$50 Copay, then 100% Copay waived if admitted	$50 Copay, then 100% Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician hospital visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit – Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician office visit - Specialist	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Second Surgical Opinion	100% of Allowed Benefit	100% of Allowed Benefit
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy shots/serum (if billed separately from office visit)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	 $20 Copay, then 100% of Allowed Benefit $30 Copay, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulance	70% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Orthotics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education – (includes diabetes Management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	100% of Allowed Benefit	100% of Allowed Benefit
Private Duty Nursing	70% of Allowed Benefit After Deductible	
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Physical	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	$35 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Related Services		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Birthing Center	100% of Allowed Benefit	100% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	PCP – $20 Copay per visit , then 100% of Allowed Benefit Specialist – $30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
PREVENTIVE CARE		
Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

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TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Drugs	$30 Copay	$60 Copay
Non-formulary Brand Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Copay**	
****** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Copay**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

Network Only Health Benefit Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days
CALENDAR YEAR DEDUCTIBLE	
Individual	$200
Individual and 1 Dependent	$400
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)
The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	
CALENDAR YEAR COINSURANCE OUT-OF-POCKET MAXIMUM	
Individual	$2,000
Individual and 1 Dependent	$4,000
Family (Employee and 2 or more Dependents)	$6,000
The **Coinsurance** Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. The following do not count towards the **Coinsurance** Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

CALENDAR YEAR WRAP OUT-OF-POCKET MAXIMUM	
Individual	$6,350
Individual and 1 Dependent	$12,700
Family (Employee and 2 or more Dependents)	$12,700

The Wrap Out-of-Pocket Maximum is the total amount the Member is responsible for paying for a Covered Service, including Deductible, Coinsurance, and medical Copays. The following do not count towards the Wrap Out-of-Pocket Maximum: prescription drug Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient * - includes room, board and ancillary services	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Newborn	$200 Copay per admission, then 100% of Allowed Benefit	Not Covered
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	80% of Allowed Benefit * After Deductible	Not Covered
Rehabilitation Facility*	80% of Allowed Benefit * After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Outpatient – includes all services billed by the Hospital	80% of Allowed Benefit After Deductible	Not Covered
Ambulatory Surgical Facility	80% of Allowed Benefit After Deductible	Not Covered
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Physician hospital visit	80% of Allowed Benefit After Deductible	Not Covered
Physician office visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered
Physician office visit - Specialist	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Second Surgical Opinion	80% of Allowed Benefit After Deductible	Not Covered
Surgery (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Allergy shots/serum (if billed separately from office visit)	80% of Allowed Benefit After Deductible	Not Covered
Allergy Testing - Primary Care Physician - Specialist	 $25 Copay, then 100% of Allowed Benefit $35 Copay, then 100% of Allowed Benefit	Not Covered
Ambulance	$75 Copay, then 100% of Allowed Benefit	
Cardiac Rehabilitation	80% of Allowed Benefit After Deductible	Not Covered
Chiropractic Care (maximum of $2,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Durable Medical Equipment	80% of Allowed Benefit After Deductible	Not Covered
Home Health Care (maximum of 100 visits per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Home Infusion Therapy	80% of Allowed Benefit After Deductible	Not Covered
Hospice Care (maximum of 180 days per Lifetime)	100 of Allowed Benefit %	Not Covered
Infertility Testing (maximum of $1,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Orthotics	80% of Allowed Benefit After Deductible	Not Covered
Patient Education – (includes diabetes Management and ostomy care)	80% of Allowed Benefit After Deductible	Not Covered
Pre-Admission Testing	80% of Allowed Benefit After Deductible	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	80% of Allowed Benefit After Deductible	Not Covered
Renal Dialysis	80% of Allowed Benefit After Deductible	Not Covered
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	80% of Allowed Benefit After Deductible	Not Covered
Urgent Care Center	$50 Copay, then 100% of Allowed Benefit	Not Covered
All Other Eligible Expenses	80% of Allowed Benefit After Deductible	Not Covered

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Maternity Related Services		
Inpatient Hospital*	$200 Copay per admission, then 100% of Allowed Benefit *	Not Covered
Birthing Center	80% of Allowed Benefit After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Physician's Charges for Delivery	80% of Allowed Benefit After Deductible	Not Covered
Pre or post natal office visits (not billed with delivery)	PCP – $25 Copay per visit then 100% of Allowed Benefit Specialist – $35 Copay per visit then 100% of Allowed Benefit	Not Covered
Laboratory tests, x-rays, diagnostic tests, specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	Not Covered
Organ Transplants		
Inpatient Hospital*	80% of Allowed Benefit * After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Transplant Procedure (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow, peripheral stem cell)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays, diagnostic tests	100% of Allowed Benefit After Deductible	Not Covered
PREVENTIVE CARE		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	Not Covered
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	Not Covered
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	$200 Copay per admission, then 100% of Allowed Benefit *	Not Covered
Inpatient Physician Visits	80% of Allowed Benefit After Deductible	Not Covered
Outpatient	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Drugs	$35 Copay	$70 Copay
Non-formulary Brand Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Copay**	
****** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Copay**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		
Over-the-Counter Option		
Non-sedating antihistamines and Prilosec (Please refer to Notes 6 and 7 below)	$10 Copay	

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services and are not covered expenses. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. Guidelines for Non-Sedating Antihistamines – Non-sedating antihistamines may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for all over-the-counter non-sedating antihistamines at the Generic Copay. Examples include Claritin, Allegra, Clarinex and Zyrtec. Keep in mind that in order for the OTC drug to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

7. Guidelines for Prilosec – Prilosec may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

- Over-the-Counter – Benefits are provided for all over-the-counter Prilosec at the Generic Copay. Keep in mind that in order for the OTC Prilosec to be covered, you must have a prescription from your Physician.
- Pharmacist-dispensed Prescriptions – Benefits are not provided for Prilosec when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

8. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

9. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

Qualified High Deductible Health Plan
Summary of Benefits

Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers).

Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the Calendar Year Deductible and pre-certification requirement, as indicated.

Pre-certification Requirement – The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.

INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One Surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,500	
Individual and 1 Dependent	$3,000	
Family (Employee and 2 or more Dependents)	$3,000	
Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except In-Network ***Preventive Services*** and Preventive Services Drugs, apply to the Deductible. Individual Deductible – This Deductible must be met once each calendar year and applies to Covered Services indicated in this Summary of Benefits. Individual and 1 Dependent Deductible / Family Deductible – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$2,000	$3,000
Individual and 1 Dependent	$4,000	$5,000
Family (Employee and 2 or more Dependents)	$6,000	$7,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit. Individual Out-of-Pocket Maximum – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of Allowed Benefit of the Allowed Benefit for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply. Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of Allowed Benefit of the Allowed Benefit for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Newborn	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician hospital visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician office visit - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Second Surgical Opinion	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy shots/serum (if billed separately from office visit)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulance	90% of Allowed Benefit After deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education – (includes diabetes Management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Birthing Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre or post natal office visits (not billed with delivery)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Preventive Care		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Drugs	90% After Deductible	90% After Deductible
Non-formulary Brand Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Brand (Chantix only) and Generic Prescription and Over-the-Counter Drugs related to Smoking Cessation, in compliance with the Patient Protection and Affordable Care Act of 2010**	**No Charge**	
****** A description of Tobacco Use Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits**		
Vaccination (travel and non-travel) at Participating Pharmacies	**No Charge**	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The charge for the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

Association Mutual Health Insurance Company
Request for Quote and Group Application

SECTION I:

Part A: Employer Contact Information

1. Employer (full legal name) _____
   _____
2. Main Address _____
   _____
3. Contact Name _____
4. Contact Title _____
5. Contact E-mail _____
6. Telephone Number _____
7. Fax Number _____
8. Website Address _____
9. Proposed Effective Date _____

Part B: Eligibility and Enrollment

10. Do you have at least five active employees? __Yes__No
    If so, what is the expected enrollment in the medical plan? _____
11. Do you have at least 75% of all benefit-eligible employees enrolled in a medical plan?
    __Yes__No
12. Please attach a copy of the IRS Determination Letter that indicates your status as a Non-Profit organization.
13. Please attach a written narrative describing how one of your organization's missions is to support education, research and/or public service.
14. Please attach a census report.
15. Please attach a copy of your most recent medical (and dental) bill and summary of benefits.

SECTION II: Proposed Choice of Coverage

Choice of Health Coverage:
- ☐ PPO Health Plan
- ☐ Kaiser Permanente Select HMO Plan
- ☐ Network Only Health Plan
- ☐ Qualified High Deductible Health Plan

Choice of Other Insurance:
- Dental (Choose one): ☐ Premium ☐ Standard
- ☐ Employee Assistance Plan (must be 100% employer paid)
- ☐ Legal Assistance
- ☐ United Healthcare Vision

☐ Flexible Spending Account ☐ Health Savings Account

☐ Life Insurance

Select One:

☐ 1x annual salary ☐ 1.5x annual salary

☐ 2x annual salary ☐ $50,000 (fixed amount)

SECTION III: Current Plan Information

1. Name of current health insurance carrier: _____

2. Name of current dental insurance carrier: _____

3. Name of current vision insurance carrier: _____

3. Current Plan Details

Health Insurance

Do you contribute at least 75% of the monthly employee only premium for the least expensive medical plan you offer?

__Yes __No

	Employee	Employee/Child	Employee/Spouse	Family
Plan I				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$
Plan II (if applicable)				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$
Plan III (if applicable)				
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$

Dental Insurance

Do you contribute at least 50% of the monthly employee dental premium? __Yes __No

	Employee	Employee/Child	Employee/Spouse	Family
Employer Contribution	$	$	$	$
Monthly Premium	$	$	$	$

Number of COBRA Participants _____

Number of Disabled Employees on the medical plan _____

Is coverage offered to retirees? __Yes __ No If so, please provide a copy of your post-retirement health policy.
# of Retirees _____

4. What other forms of health and welfare plans are available to your employees?

SECTION IV: Underwriting

1. To the best of your information and belief, is there any eligible person who has been treated for:

____ Birth Defects or Disorders	____ Existing Pregnancy
____ Cancer	____ Psychiatric Disorders
____ Chronic Heart, Kidney or Liver Disease	____ Substance Abuse

2. To the best of your information and belief, is there any eligible person who has incurred $10,000 or more in medical expenses in the last 12 months or expects to be hospitalized for a serious medical condition? __Yes __No

3. To the best of your information and belief, is there any eligible person to be enrolled for group coverage who has been denied coverage by your current or last health care carrier? __Yes __No

4. Has the company changed health carriers three (3) times in the past five (5) years? __Yes __No

5. Has the company's coverage been cancelled or is it in the process of being cancelled by the company's current carrier? __Yes __ No

6. Has the company filed for or is in the process of filing for bankruptcy? __Yes __No

SECTION V: Request for Quotation:

I declare that the information given on this application is true and complete to the best of my knowledge and belief.

My organization hereby requests approval to participate in the Employee Benefit Plans(s) offered by AMHIC/SBPA as stated in Section II.

_____

Printed Name Date

_____

Authorized Signature Title

Association Mutual Health Insurance Company

PPO Health Benefit Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) PPO Health Benefit Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, hospice care, and private-duty nursing.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO
HEALTH BENEFIT PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is a preferred provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC PPO Heath Benefit Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC PPO Health Benefit Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductible, Copays, and Coinsurance

The AMHIC PPO Health Benefit Plan is a preferred provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use Network Providers. When you obtain services from a Non-Network Provider, you will usually receive a lower level of benefits (with a few exceptions as outlined in *Section 2 - Summary of Benefits*). If this is the case, your out-of-pocket costs will be more.

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible, Copay and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2
SUMMARY OF BENEFITS

PPO Health Benefit Plan Summary of Benefits		
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.		
Pre-Certification Requirement - The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.		
INDIVIDUAL LIFETIME MAXIMUMS		
Overall Medical Maximum	Unlimited	
Hospice Care	180 days	
Surgery required as the result of Morbid Obesity*	One surgery	
INDIVIDUAL CALENDAR YEAR MAXIMUMS		
Acupuncture	$2,000	
Chiropractic Care	$2,000	
Home Health Care	100 visits	
Infertility Testing	$1,000	
Skilled Nursing/Extended Care Facility	100 days	
	Network Provider (In-Network)	**Non-Network Provider (Out-of-Network)**
CALENDAR YEAR DEDUCTIBLE		
Individual	$200	$300
Individual and 1 Dependent	$400	$600
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)	$900 (No more than $300 per Individual can be applied toward the Family Deductible)
Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$1,000	$2,000
Individual and 1 Dependent	$2,000	$4,000
Family (Employee and 2 or more Dependents)	$3,000	$6,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.		

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TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Newborn	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit*	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	$50 Copay, then 100% Copay waived if admitted	$50 Copay, then 100% Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Hospital Visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician Office Visit - Specialist	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Second Surgical Opinion	100% of Allowed Benefit	100% of Allowed Benefit
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit	70% of Allowed Benefit After Deductible

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TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Shots/Serum (if billed separately from office visit)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	 $20 Copay, then 100% of Allowed Benefit $30 Copay, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Ambulance	70% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education (includes diabetes management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	100% of Allowed Benefit	100% of Allowed Benefit
Private Duty Nursing	70% of Allowed Benefit After Deductible	
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Physical	$30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	$35 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Birthing Center	100% of Allowed Benefit	100% of Allowed Benefit
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	PCP – $20 Copay per visit, then 100% of Allowed Benefit Specialist – $30 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit	70% of Allowed Benefit After Deductible
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

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TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	$100 Copay, then 100% of Allowed Benefit up to $5,000, then 90% per admission*	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	$20 Copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit After Deductible

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Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$30 Copay	$60 Copay
Non-Formulary Brand Name Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Copay is paid and the Deductible has been met.

Copay − A flat dollar amount a Participant must pay to receive a specific service or benefit. *Section 2 - Summary of Benefits* shows the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Host Blue – An on-site Blue Cross and/or Blue Shield Licensee providing benefits for Covered Services to the Participant outside of the CareFirst Administrators local Service Area(s).

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more

(35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife

Birthing Center
Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Certified Registered Nurse Anesthetist
Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;

5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;
6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;
2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

"Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of

coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits* are based on the In-Network benefit level and the Allowed Benefit.

AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when

transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.

2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the

Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;

5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

<u>Hemodialysis</u>

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
    d. Food services or meals other than dietary counseling.
    e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
    f. Private duty nursing.
    g. Services by volunteers or people who do not regularly charge for their services.
    h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care.***

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

    a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
    b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.

3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*

4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.
8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated

marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);
    g. Neuroblastoma Stage III or IV in children;
    h. Homozygous beta thalassemia (thalassemia major);
    i. Hodgkin's lymphoma;
    j. Non-Hodgkin's lymphoma;
    k. Myelodysplastic syndromes;
    l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
    m. Multiple myeloma;
    n. Sickle-cell anemia;
    o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.
12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

Private Duty Nursing

Definition - Services that require the training, judgment, and technical skills of an actively practicing registered nurse (RN) or licensed practical nurse (LPN). Such services must be prescribed by your attending Physician for the continuous medical treatment of your condition.

Medical-Surgical Benefits

Outpatient: We will allow benefits for private duty nursing services in your home or other outpatient location.

Limitations and Exclusions

1. **Alternative Care** — We will not allow benefits for nursing services ordinarily provided by a Hospital staff or its intensive care or coronary care units.
2. **Claims Review** — All claims are subject to review to ensure that private duty nursing services are absolutely required. The fact that private duty nursing services are a benefit under this Certificate does not guarantee that any or all services will be covered.
3. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Family Members** — We will not allow benefits for services provided by a family member, regardless of the circumstances.
5. **Maximum Payment Limits** — Private duty nursing benefits are limited to one eight-hour shift per day.
6. **Physician's Certification** — All claims for private duty nursing services must include a Physician's certification that such services are Medically Necessary. The billing must also indicate the nurse's degree and license number.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.
2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;
    d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
    e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
    f. Deafness;
    g. Disorders of cognitive etiology;
    h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

    a. Artificial arms, legs, or eyes.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Maxillofacial prostheses.
    e. Cervical collars.
    f. Surgical implants.
    g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.
5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.

2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:

    a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
    b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***
7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*

12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Copay amounts are as follows:

PRESCRIPTION DRUG PLAN	Copay per Prescription	
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$30 Copay	$60 Copay
Non-Formulary Brand Name Drugs	$50 Copay	$100 Copay
Over-the-Counter Drugs related to Preventive Services as specified by PPACA**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest Copay.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher Copay.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Copay. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher Copay for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services – Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.
7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an “off-label” use. This can mean that the drug is:

1. used for a different disease or medical condition;

2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
3. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
4. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
5. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
6. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
7. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.

8. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;
    c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
    d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
    e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
    f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
    g. Drugs and supplies unless specifically included as a covered drug;
    h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
    i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

9. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.
10. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
11. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
12. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
13. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
14. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
15. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Copay as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription Copay expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Copay and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Copay. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription Copay. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.
2. **Copay** — The predetermined fixed-dollar or percentage amount that the Participant must pay for each separate prescription or refill of a covered drug.
3. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
4. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay as a Copay for each prescription, with drugs listed on the Formulary typically available at a lower Copay to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
5. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
6. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.

7. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
8. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Copay.
9. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

10. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
11. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
12. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
13. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible, Copay and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission.

Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond

the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a

statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is

incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO. The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the

IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and

(3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the

Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any other person or entity to whom an assignment of benefits has been made by a Participant or

Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

    a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
    b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

    We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the

group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this PPO Health Benefit Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N Byer

Name: Rhona N Byer

Title: Executive Director

Date: 11/7/2013

Association Mutual Health Insurance Company

Network Only Health Benefit Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) Network Only Health Benefit Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, and hospice care.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY
HEALTH BENEFIT PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is an exclusive provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC Network Only Heath Benefit Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC Network Only Health Benefit Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductible, Copays, and Coinsurance

The AMHIC Network Only Health Benefit Plan is an exclusive provider plan. In general, benefits are not provided for services rendered by Non-Network Providers (with a few exceptions as outlined in *Section 2 - Summary of Benefits*).

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible, Copay and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2

SUMMARY OF BENEFITS

Network Only Health Benefit Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-Certification Requirement - The items marked below with an asterisk (*) ***require*** pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days
CALENDAR YEAR DEDUCTIBLE	
Individual	$200
Individual and 1 Dependent	$400
Family (Employee and 2 or more Dependents)	$600 (No more than $200 per Individual can be applied toward the Family Deductible)
The following do not count towards the Deductible: Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	
Individual	$2,000
Individual and 1 Dependent	$4,000
Family (Employee and 2 or more Dependents)	$6,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. The following do not count towards the Out-of-Pocket Maximum: Deductibles, Copays, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit.	

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Newborn	$200 Copay per admission, then 100% of Allowed Benefit	Not Covered
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	80% of Allowed Benefit* After Deductible	Not Covered
Rehabilitation Facility*	80% of Allowed Benefit* After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted	$100 Copay, then 100% of Allowed Benefit Copay waived if admitted
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Outpatient – includes all services billed by the Hospital	80% of Allowed Benefit After Deductible	Not Covered
Ambulatory Surgical Facility	80% of Allowed Benefit After Deductible	Not Covered
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered
Emergency Room - Accidental Injury or Medical Emergency	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	80% of Allowed Benefit After Deductible	Not Covered
Physician Hospital Visit	80% of Allowed Benefit After Deductible	Not Covered
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered
Physician Office Visit - Specialist	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Second Surgical Opinion	80% of Allowed Benefit After Deductible	Not Covered
Surgery (Inpatient and Outpatient)	80% of Allowed Benefit After Deductible	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	$35 Copay per visit, then 100% of Allowed Benefit	Not Covered
Allergy Shots/Serum (if billed separately from office visit)	80% of Allowed Benefit After Deductible	Not Covered
Allergy Testing - Primary Care Physician - Specialist	 $25 Copay, then 100% of Allowed Benefit $35 Copay, then 100% of Allowed Benefit	Not Covered
Ambulance	$75 Copay, then 100% of Allowed Benefit	
Cardiac Rehabilitation	80% of Allowed Benefit After Deductible	Not Covered
Chiropractic Care (maximum of $2,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Durable Medical Equipment	80% of Allowed Benefit After Deductible	Not Covered
Home Health Care (maximum of 100 visits per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Home Infusion Therapy	80% of Allowed Benefit After Deductible	Not Covered
Hospice Care (maximum of 180 days per Lifetime)	100% of Allowed Benefit	Not Covered
Infertility Testing (maximum of $1,000 per calendar year)	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Orthopedic Appliance	80% of Allowed Benefit After Deductible	Not Covered
Patient Education (includes diabetes management and ostomy care)	80% of Allowed Benefit After Deductible	Not Covered
Pre-Admission Testing	80% of Allowed Benefit After Deductible	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	80% of Allowed Benefit After Deductible	Not Covered
Renal Dialysis	80% of Allowed Benefit After Deductible	Not Covered
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	80% of Allowed Benefit After Deductible	Not Covered
Urgent Care Center	$50 Copay, then 100% of Allowed Benefit	Not Covered
All Other Eligible Expenses	80% of Allowed Benefit After Deductible	Not Covered

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Birthing Center	80% of Allowed Benefit After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Physician's Charges for Delivery	80% of Allowed Benefit After Deductible	Not Covered
Prenatal or postnatal office visits (not billed with delivery)	PCP – $25 Copay per visit then 100% of Allowed Benefit Specialist – $35 Copay per visit then 100% of Allowed Benefit	Not Covered
Laboratory tests, x-rays, diagnostic tests, specialty imaging	100% of Allowed Benefit After Deductible	Not Covered
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	Not Covered
Organ Transplants		
Inpatient Hospital*	80% of Allowed Benefit* After Deductible	Not Covered
Anesthesia	80% of Allowed Benefit After Deductible	Not Covered
Transplant Procedure	80% of Allowed Benefit After Deductible	Not Covered
Laboratory tests, x-rays, diagnostic tests	100% of Allowed Benefit After Deductible	Not Covered
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	Not Covered
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	Not Covered
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	$200 Copay per admission, then 100% of Allowed Benefit*	Not Covered
Inpatient Physician Visits	80% of Allowed Benefit After Deductible	Not Covered
Outpatient	$25 Copay per visit, then 100% of Allowed Benefit	Not Covered

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$35 Copay	$70 Copay
Non-Formulary Brand Name Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		
Over-the-Counter Option		
Non-sedating antihistamines and Prilosec (Please refer to Notes 6 and 7 below)	$10 Copay	

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services and are not covered expenses. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. Guidelines for Non-Sedating Antihistamines – Non-sedating antihistamines may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for all over-the-counter non-sedating antihistamines at the Generic Copay. Examples include Claritin, Allegra, Clarinex and Zyrtec. Keep in mind that in order for the OTC drug to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

7. Guidelines for Prilosec – Prilosec may either be obtained in over-the-counter (OTC) form or dispensed by a pharmacist. Your Physician can prescribe either type. The following guidelines explain the benefits:

   - Over-the-Counter – Benefits are provided for over-the-counter Prilosec at the Generic Copay. Keep in mind that in order for OTC Prilosec to be covered, you must have a prescription from your Physician.
   - Pharmacist-dispensed Prescriptions – Benefits are not provided for Prilosec when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

8. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

9. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Copay is paid and the Deductible has been met.

Copay − A flat dollar amount a Participant must pay to receive a specific service or benefit. *Section 2 - Summary of Benefits* shows the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Host Blue – An on-site Blue Cross and/or Blue Shield Licensee providing benefits for Covered Services to the Participant outside of the CareFirst Administrators local Service Area(s).

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more

(35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife

Birthing Center
Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Certified Registered Nurse Anesthetist
Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;
5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;
6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;

2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

    "Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

    Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the

qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an

Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled

continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits are* based on the In-Network benefit level and the Allowed Benefit.

AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when

transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.

2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the

Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;

5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

<u>Hemodialysis</u>

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
    d. Food services or meals other than dietary counseling.
    e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
    f. Private duty nursing.
    g. Services by volunteers or people who do not regularly charge for their services.
    h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care.***

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

    a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
    b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.

3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*

2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*

4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.
8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated

marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;
2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);
    g. Neuroblastoma Stage III or IV in children;
    h. Homozygous beta thalassemia (thalassemia major);
    i. Hodgkin's lymphoma;
    j. Non-Hodgkin's lymphoma;
    k. Myelodysplastic syndromes;
    l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
    m. Multiple myeloma;
    n. Sickle-cell anemia;
    o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.
12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.
2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;
    d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
    e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
    f. Deafness;
    g. Disorders of cognitive etiology;
    h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*****.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

a. Artificial arms, legs, or eyes.
b. Leg braces, including attached shoes.
c. Arm and back braces.
d. Maxillofacial prostheses.
e. Cervical collars.
f. Surgical implants.
g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.
5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural

procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:
   a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
   b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***
7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*
12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Copay amounts are as follows:

PRESCRIPTION DRUG PLAN	Copay per Prescription	
	Retail (30-day supply)	**Mail Order (90-day supply)**
Generic Drugs	$10 Copay	$20 Copay
Formulary Brand Name Drugs	$35 Copay	$70 Copay
Non-Formulary Brand Name Drugs	$70 Copay	$140 Copay
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Copay	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Copay	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Over-the-Counter Option	**Retail Pharmacy**	
Non-sedating antihistamines and Prilosec	$10 Copay	

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Copay plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest Copay.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should

determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher Copay.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Copay. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Over-the-Counter Option - In addition to the prescription drug benefits described above, your Prescription Drug Plan provides benefits for OTC non-sedating antihistamines, when prescribed by a Physician. To be eligible for benefits, you must present your prescription to the Pharmacy when you purchase the drug. You will only be required to pay the Generic Copay. Examples of OTC non-sedating antihistamines include Claritin, Allegra, Clarinex and Zyrtec.

Benefits are not provided for non-sedating antihistamines when dispensed by a pharmacist from a written prescription. In this case, you will pay the entire amount for the drug.

The Prescription Drug Plan also provides benefits for the OTC proton pump inhibitor, Prilosec, when prescribed by a Physician. You will only be required to pay the Generic Copay at the time you purchase OTC Prilosec with a prescription from your Physician.

If you purchase your OTC drug from a Non-Network Pharmacy or do not have your Identification Card with you at the time of purchase, you may submit a claim directly to Express Scripts. To do so, please complete a prescription drug claim form, attach the prescription from the Physician and the receipt you received from the Pharmacy, and send it to Express Scripts. The Prescription Drug Plan will pay the cost of the drug, less the Generic Copay amount.

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher Copay for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the

Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.

7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Antihistamines** – Prescription non-sedating antihistamines dispensed by a pharmacist are not covered. Only OTC non-sedating antihistamines, when prescribed by a Physician, are covered.

3. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
4. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
5. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
6. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
7. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
8. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.
9. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;
    c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
    d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
    e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
    f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
    g. Drugs and supplies unless specifically included as a covered drug;
    h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
    i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

10. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.

11. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
12. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
13. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
14. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
15. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
16. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Copay as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription Copay expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Copay and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Copay. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription Copay. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own

registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.

2. **Copay** — The predetermined fixed-dollar or percentage amount that the Participant must pay for each separate prescription or refill of a covered drug.
3. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
4. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay as a Copay for each prescription, with drugs listed on the Formulary typically available at a lower Copay to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
5. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
6. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.
7. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
8. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Copay.
9. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

10. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
11. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

12. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, “Caution: Federal law prohibits dispensing without a prescription.” Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
13. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Copay. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible, Copay and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Benefits are not provided for services rendered by Non-Network Providers, other than Medically Necessary ambulance services, Medical Emergencies, and certain exceptions listed in *Section 2 - Summary of Benefits*. Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any

such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman

established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO.

The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, Texas 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant

or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and (3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other

Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any

other person or entity to whom an assignment of benefits has been made by a Participant or Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any

court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
   b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

   We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY HEALTH BENEFIT PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this Network Only Health Benefit Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N. Byer

Name: Rhona N. Byer

Title: Executive Director

Date: 11/7/2013

Association Mutual Health Insurance Company

Qualified High Deductible Health Plan

Certificate of Coverage

January 1, 2013

WELCOME

We are very pleased to welcome you as a Member of the Association Mutual Health Insurance Company (AMHIC) Qualified High Deductible Health Plan (the "Plan"). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, and hospice care.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-Certification, Continued Stay Review, Pre-Notification, and Large Case Management. These programs ensure that you receive Medically Necessary care in the most cost-effective manner. These Cost Containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with health care Provider networks to provide services to our Members. When you receive care from a contracted Network Provider, your benefits will be paid at a higher level. Network Providers will file claims for you, and payments will be made directly to them. In order to ensure the proper use of the medical care system, you should establish an ongoing relationship with a Network Provider.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

This Plan is a preferred provider plan offered by AMHIC based on benefits, limitations, exclusions, and payment as determined by AMHIC.

Your AMHIC Qualified High Deductible Heath Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Plan when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Plan benefits to you, the Member. As a Member, you are bound by all the terms of this Certificate.

AMHIC shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. AMHIC's decision shall be final regarding your eligibility for benefits.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC.

If the Plan is terminated or amended or benefits are eliminated, the rights of Participants are limited to covered expenses incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform its duties thereunder.

How to Read This Certificate - This Certificate is designed to make it easy for you to determine your benefits. For instance, if you need to know the benefit for a surgery, turn to *Section 6 - Your Benefits.* The ***Surgery*** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. **NOTE**: Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for Plan payments only with respect to particular types of care.

The last part of each subsection in *Section 6 - Your Benefits* lists the most important limitations and exclusions to that particular service. *Section 7 - General Limitations and Exclusions* lists other limitations and exclusions, which apply to all benefits. **The items in *Section 7- General Limitations and Exclusions* apply to all services and supplies, whether or not these items are listed separately within any benefits subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Identification Cards - After you enroll in this Plan, you and your Dependents, if any, will receive an AMHIC Qualified High Deductible Health Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (877) 889-2478. A new Identification Card will be sent to you.

Finding a Network Provider - There are different ways for you to find out if a health care Provider is a Network Provider. To find out if a health care Provider is a Network Provider, you may look at the network's website. To access your network's website, go to www.amhic.com or www.cfablue.com. Since a Provider's status within the network is subject to change, it would be best to confirm that the Provider participates by calling the Provider directly.

Pre-Certification Requirements - If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary. To obtain admission pre-certification, call the Managed Care Vendor (InforMed) at (866) 475-1256.

How We Calculate Deductibles and Coinsurance

The AMHIC Qualified High Deductible Health Plan is a preferred provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use Network Providers. When you obtain services from a Non-Network Provider, you will usually receive a lower level of benefits (with a few exceptions as outlined in *Section 2 - Summary of Benefits*). If this is the case, your out-of-pocket costs will be more.

AMHIC has contracted with networks of participating health care Providers in an attempt to control the costs of health care. As part of this effort, many Network Providers agree to give discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that Network Providers can provide all services all the time, and services performed by Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the Allowed Benefit, as contracted between the Provider and the network, as payment in full for Covered Services. For example, your Physician may charge $100 for a procedure, and the network's Allowed Benefit is $85. Your Deductible and Coinsurance are based on the network's Allowed Benefit of $85, and not the Physician's charge of $100.

You benefit from all network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductible and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer.

SECTION 2

SUMMARY OF BENEFITS

Qualified High Deductible Health Plan Summary of Benefits	
Important Note: Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers). Payments to Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. Covered Services are subject to the calendar year Deductible and pre-certification requirement, as indicated.	
Pre-Certification Requirement - The items marked below with an asterisk (*) *require* pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to *Section 5 - Cost Containment Features*.	
INDIVIDUAL LIFETIME MAXIMUMS	
Overall Medical Maximum	Unlimited
Hospice Care	180 days
Surgery required as the result of Morbid Obesity*	One surgery
INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Acupuncture	$2,000
Chiropractic Care	$2,000
Home Health Care	100 visits
Infertility Testing	$1,000
Skilled Nursing/Extended Care Facility	100 days

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
CALENDAR YEAR DEDUCTIBLE		
Individual	$1,500	
Individual and 1 Dependent	$3,000	
Family (Employee and 2 or more Dependents)	$3,000	
Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except In-Network ***Preventive Services*** and Preventive Services Drugs, apply to the Deductible. Individual Deductible – This Deductible must be met once each calendar year and applies to Covered Services indicated in this Summary of Benefits. Individual and 1 Dependent Deductible / Family Deductible – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM		
Individual	$2,000	$3,000
Individual and 1 Dependent	$4,000	$5,000
Family (Employee and 2 or more Dependents)	$6,000	$7,000
The Out-of-Pocket Maximum is the amount the Member is responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, and charges in excess of the Allowed Benefit. Individual Out-of-Pocket Maximum – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of the Allowed Benefit for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply. Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of the Allowed Benefit for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.		

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Inpatient* - includes room, board and ancillary services	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Newborn	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Rehabilitation Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient – includes all services billed by the Hospital	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% of Allowed Benefit After Deductible	90% of Allowed Benefit After Deductible
Emergency Room - for HIV screening	100% of Allowed Benefit	100% of Allowed Benefit
Emergency Room - Non-Medical Emergency	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Hospital Visit	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician Office Visit - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Second Surgical Opinion	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Surgery (Inpatient and Outpatient)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Shots/Serum (if billed separately from office visit)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Ambulance	90% of Allowed Benefit After Deductible	
Cardiac Rehabilitation	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Chiropractic Care (maximum of $2,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Durable Medical Equipment	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Health Care (maximum of 100 visits per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Home Infusion Therapy	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Hospice Care (maximum of 180 days per Lifetime)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Infertility Testing (maximum of $1,000 per calendar year)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Patient Education (includes diabetes management and ostomy care)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
All Other Eligible Expenses	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Maternity Services		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Birthing Center	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Physician's Charges for Delivery	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal or postnatal office visits (not billed with delivery)	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Prenatal Screening as defined under Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Anesthesia	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Transplant Procedure	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Preventive Services		
Preventive Services for eligible adults and children, in compliance with the Patient Protection and Affordable Care Act of 2010**	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Women's Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010***	100% of Allowed Benefit	70% of Allowed Benefit After Deductible
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility*	90% of Allowed Benefit* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible
Outpatient	90% of Allowed Benefit After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact it prior to admittance (or within one business day after an emergency admission) to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of $500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

Prescription Drugs	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Non-Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".		

NOTES:

1. Benefits for services provided by a Network Provider are payable as shown in *Section 2 - Summary of Benefits*. To obtain In-Network benefits, you must use a Network Provider. Since the list of participating Network Providers is subject to change, it is best to confirm that a particular Provider participates by calling the Provider prior to receiving services.

2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider. However:

   a. If you utilize a Network Hospital or other facility which is a Network Provider and receive services from a Non-Network Provider; or
   b. If Medically Necessary services are not available from a Network Provider (because the network does not contract with the appropriate specialty),

   then the services will be paid at the In-Network benefit level, based on the Allowed Benefit. All other limitations, requirements and provisions of this Plan will apply.

   This exception does not apply in the event you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

3. The charge for the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.

4. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.

5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.

6. If the Participant receives care in an emergency room for an Accidental Injury or a Medical Emergency at a Non-Network Hospital, eligible expenses will be covered at the In-Network benefit level, based on the Allowed Benefit. If the Participant is admitted on an emergency basis to a facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level, based on the Allowed Benefit.

7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in *Section 2 - Summary of Benefits*. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee – Employees who report for work with the Employer at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, full-time basis, as specified in *Section 4 – Membership Eligibility*. If your usual place of employment is in your home, you will be considered Actively at Work if, at any time on the date in question, you are neither:

1. Confined in a Hospital; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, full-time basis.

As an Employee, you will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which you are not totally disabled, provided you were Actively at Work on the last preceding regular working day.

Alcoholism Treatment Center − A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Allowed Benefit – For a Provider that has contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service is the lesser of:

1. The actual charge which, in some cases, will be a rate set by a regulatory agency; or
2. The amount CareFirst Administrators allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Provider and is accepted as payment in full, except for any applicable Participant payment amounts as stated in the Certificate.

For a Physician or other professional Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Provider that has contracted with CareFirst Administrators. The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

For a Hospital or other facility Provider that has not contracted with CareFirst Administrators, the Allowed Benefit for a Covered Service will be:

1. The rate approved by the Health Services Cost Review Commission (HSCRC) for those hospitals or facilities for which the HSCRC has authority; and
2. Based upon the lower of the Provider's usual charge, or the established Allowed Benefit if one has been established for that type of eligible Provider and service. In some cases,

and on an individual basis, CareFirst Administrators is able to negotiate a lower rate. In these instances, the Allowed Benefit will be the negotiated rate.

The benefit is payable to the Participant, or to the Provider, at the discretion of CareFirst Administrators. The Participant is responsible for any applicable Participant payment amounts as stated in the Certificate, and for the difference between the Allowed Benefit and the Provider's actual charge.

Ambulatory Surgical Center − A licensed facility that is used mainly for performing outpatient surgery, which has a staff of Physicians and continuous Physician and nursing care by registered nurses and does not provide for overnight stays.

Ancillary Services − See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits*.

AMHIC − Association Mutual Health Insurance Company, incorporated in the District of Columbia.

Birthing Center − Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery admission.

Certificate of Creditable Coverage – A written document that reflects certain details about an individual's prior Creditable Coverage, for purposes of reducing the extent to which a plan offering health coverage may apply a pre-existing condition exclusion. You should have received a certificate from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your Creditable Coverage to reduce your Pre-existing Condition Waiting Period under this Plan.

COBRA − Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate − This document which contains information regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Claims Administrator – The Claims Administrator is CareFirst Administrators, which is an organization that provides services in connection with the operation of this Plan and performs other functions, including processing and payment of claims, as may be delegated to it.

Coinsurance − The percentage of the cost of Covered Services that a Participant must pay after the Deductible has been met.

Cost Containment − A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any Participant who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this Plan.

Covered Services − Services and supplies provided to a Participant for which the Plan has an obligation to pay under the terms of this Certificate.

Creditable Coverage − Coverage under almost any type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable Coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-existing Condition Waiting Period.

Customer Service Department − AMHIC's Customer Service Department for medical benefits is *c/o CareFirst Administrators, P.O. Box 981608, El Paso, TX, 79998, 1-877-889-2478*. The Customer Service Department for prescription drug benefits is *Express Scripts, Inc., 1-800-451-6245*.

Deductible − A specified amount of expense for Covered Services that the Participant must pay within each Plan Year before the Plan provides benefits. *Section 2 - Summary of Benefits* shows the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent − An individual who meets the dependent eligibility requirements described in *Section 4 – Membership Eligibility*.

Disability (Disabled) − In the case of a Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Effective Date − The date when you or your covered Dependent(s) become covered under the Plan.

Eligibility Waiting Period – The period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire. The Eligibility Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Employer − Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date − For purposes of HIPAA, the first day of coverage or, if there is an Eligibility Waiting Period, the first day of hire.

ERISA − Employee Retirement Income Security Act of 1974, as amended.

Experimental / Investigational – The use of any drug, device, supply, medical treatment or procedure not yet recognized by the Plan as acceptable medical practice. The Plan defines a

drug, device, medical treatment or procedure as Experimental or Investigational if any of the following criteria apply:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. Reliable Evidence shows the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

However, a service or supply will not be considered Experimental or Investigational if the Plan determines that:

1. The disease can be expected to cause death within one year, in the absence of effective treatment; and
2. The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Plan will take into account the results of a review of a panel of independent medical professionals.

This exception also applies with respect to drugs that:

1. Have been granted treatment investigational new drug (IND) or Group/treatment IND status; or
2. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, if the Plan determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

FMLA – Family and Medical Leave Act of 1993, as amended.

Hazardous Pursuits − Involve or expose an individual to risk of a degree or nature either (1) not customarily undertaken in the course of the Employee's customary occupation with the Employer or (2) not in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing,

motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide − A person licensed or certified to provide home health care services.

Home Health Care Agency − An agency certified by the state as meeting the provisions of Title XVIII of the Social Security Act, as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging for and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Hospice Agency – An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital – A health care institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Illness − A bodily disorder, disease, physical sickness or mental disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Identification Card – The card we give you that shows such information as the Member name, Member ID and Group ID numbers, and type of coverage.

Injury − Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions.

Legal Guardian − A person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Licensed Provider - A Provider, Hospital, or Physician that is licensed by the state in which he or she practices or in which the entity is located and that provides Covered Services within the scope of such license.

Lifetime − A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period during which the Participant is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Participant.

Managed Care Vendor - The Managed Care Vendor is InforMed, which is an organization that administers the Cost Containment provisions of this Plan.

Medicaid – Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, as amended.

Medical Emergency − The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her

unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. **Note**: You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Medically Necessary / Medical Necessity – Any health care treatment, service or supply determined by the Plan to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
3. It is furnished by a Provider with appropriate training and experience, acting within the scope of his/her license, and it is provided at the most appropriate level of care needed to treat the particular condition; and
4. When specifically applied to inpatient care, Medically Necessary also means the Participant's condition could not be treated safely on an outpatient basis.

The Claims Administrator will determine whether these requirements have been met based on:

1. Published reports in authoritative medical and scientific literature;
2. Regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration and Centers for Medicare & Medicaid Services;
3. Listings in compendia such as: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*; and
4. Other authoritative medical resources to the extent the Claims Administrator determines them to be necessary.

Service or supplies that are for the convenience of a Participant or Provider are not considered Medically Necessary.

Medicare – Health insurance for the aged and disabled as established by Title I of Public Law 89-98 (79 Statutes 291) including Parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member – The Participant or Employee in whose name the membership in the Plan is established and to whom the Identification Card is issued.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or an individual who has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause or contribute to the development of a condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Network Provider/Network Hospital – A Provider that participates in the network with which AMHIC has contracted to provide health care services to its Members. Contact the Claims Administrator or access the network's website to determine if a Provider participates.

Non-Network Provider/Non-Network Hospital – Any Provider that does not participate in the network with which AMHIC has contracted to provide health care services to its Members.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an "off-label" use. This can mean that the drug is:

1. used for a different disease or medical condition;
2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Participant – Any eligible Employee or Member and such person's eligible Dependent who has elected coverage in this Plan and who has fulfilled all requirements to continue participation.

Pay, Paid, or Payment – "Pay" means to satisfy a debt or obligation. After the Allowed Benefit is determined, the Plan will satisfy its percentage of the bill by an actual dollar Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Participant's portion of the payment includes Deductible and Coinsurance or other cost-sharing amounts.

Pharmacy − A licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician – A licensed health care practitioner holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption – The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's

adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan Year – January 1st – December 31st.

PPACA – Patient Protection and Affordable Care Act of 2010, as amended.

Pre-Certification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Pre-existing Condition – Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pre-existing Condition does not include (1) pregnancy (2) genetic information in the absence of any diagnosis of a condition related to such information or (3) any condition for which a Participant who has not attained age 19 received services.

Pre-existing Condition Waiting Period – A 10-month period, beginning on a Participant's Enrollment Date, during which the Participant is not eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

Pre-Notification – See ***How The Managed Care Program Works*** under *Section 5 - Cost Containment Features.*

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the effective date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Members if the Employer fails to make Premium payments.

Preventive Services Drugs – Preventive Services Drugs include the following drug categories: cardiovascular disease prevention, fracture prevention, prevention of infection, prenatal care, breast cancer prevention, diabetes-related complication prevention, nutritional disorders during childhood prevention, and anti-asthmatic and bronchodilator agents. Preventive Services Drugs also include over-the-counter (OTC) drugs related to Preventive Services and FDA-approved generic drugs and OTC drugs, devices, and supplies related to Women's Preventive Services, in compliance with the Patient Protection and Affordable Act of 2010.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted by a health plan.

Provider – A Hospital, Physician, or other health care professional or facility that is a Licensed Provider. Other providers may include, but are not limited to:

Facility / Institutional	**Professional**
Alcohol Treatment Center	Acupuncturist
Ambulance Service	Audiologist
Ambulatory Surgical Facility	Certified Nurse Midwife
Birthing Center	Certified Registered Nurse Anesthetist

Skilled Nursing/Extended Care Facility
Free-Standing Laboratory Facility
Home Health Care Agency
Home Infusion Therapy Agency
Hospice Agency
Pharmacy
Renal Dialysis Facility
Rehabilitation Facility
Residential Treatment Facility

Licensed Clinical Social Worker
Licensed Practical or Vocational Nurse
Licensed Professional Counselor
Nurse Practitioner
Occupational Therapist
Physical Therapist
Registered Nurse
Registered Nurse Clinical Specialist
Respiratory Therapist
Speech Pathologist

Retiree – An individual who meets the retiree eligibility requirements described in *Section 4 – Membership Eligibility.*

Room Expenses – See ***Room Expenses and Ancillary Services*** under *Section 6 - Your Benefits***.**

Security Incidents – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, as defined in 45 CFR § 164.304.

Significant Break in Coverage – A break in coverage of 63 days or more. Waiting periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the Plan when evaluating whether to impose a Pre-existing Condition Waiting Period.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee – All regular, benefits-eligible Active Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of 20 hours per week, and their Dependents, are eligible for membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible for membership.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement with the Employer for a period of at least six months are eligible for membership. The Employer must cover any such individuals as a class, providing the same level of Employer contributions to all members of the class as set forth in a written policy or manual.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth by the Employer and AMHIC are eligible for membership. To be considered a qualified retiree, you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

1. You must have attained age 55 with 10 or more years of active service with one of the participating organizations of AMHIC; or
2. You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC-qualified retiree. Covered retirees are not permitted to add Dependents during Open Enrollment.

AMHIC-eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from Active Employee status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage.

Check with your Human Resources Department to see if your Employer has a retirement health care policy.

Dependents – Eligible Dependents are:

1. A legal Spouse as defined under the laws of the state where the Employee lives;
2. A Child, regardless of student status, marital status, residency, financial dependency on the Employee, or eligibility for coverage under another group health plan, through the end of the month in which the Child attains age 26;

3. Your same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy;
4. An unmarried Child who has attained age 26 who is incapable of self-support because of mental incompetence or severe physical handicap and is dependent on the Employee for financial support, as certified by a Physician and the Plan. The condition must begin before or during the month in which the Child attains age 26. Adequate proof of the Child's Disability must be provided each Plan Year.
5. Any Child of an Employee who does not qualify as a Dependent under subsections 2 or 4 above solely because the Child is not primarily dependent upon the Participant for support, so long as over one-half of the support of the Child is received by the Child from the Employee pursuant to a Qualified Medical Child Support Order. Alternate recipients are eligible for coverage only if the Employee is also covered under this Plan.

A Spouse, Domestic Partner or Child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse"** or **"Domestic Partner"** means the person recognized, under the laws of the state where the covered Employee lives, as the covered Employee's husband, wife, or same- or opposite-gender Domestic Partner as defined by the AMHIC Domestic Partner Policy. AMHIC may require documentation proving a legal relationship. You must notify AMHIC if your Spouse, Domestic Partner or Child has access to health insurance coverage under another plan, such as through coverage provided by your Spouse's or Domestic Partner's Employer or as the result of a divorce decree.

The term "**Child(ren)**" means any of an Employee's:

1. Biological children;
2. Legally adopted children or children placed in the Employee's home pending final adoption;
3. Stepchildren;
4. Foster children (provided the foster child is not a ward of the state);
5. Children who are under the Legal Guardianship of the Employee;
6. Children of a Domestic Partner;
7. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
8. Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation may include:

1. A Birth Certificate;
2. A Marriage License;
3. Court documentation establishing legal separation, guardianship or adoption;
4. AMHIC Affidavit of Domestic Partnership;
5. Medicare Parts A & B card (if Employer has an AMHIC-approved retiree policy);
6. Proof of Loss of Coverage;
7. Certificate of Creditable Coverage (HIPAA);
8. Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee – To become covered by the Plan, you must complete and sign an enrollment application within 31 days of the date of your eligibility date. Please check with your Employer to confirm your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing employee, employee plus spouse, employee plus child(ren), or family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you decline enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. Coverage will be effective on the date following the day on which your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by AMHIC, the Employee stated in writing that the other coverage is the reason for declining enrollment and either:

1. The Employee (or Dependent) was previously covered under COBRA and the COBRA coverage was exhausted;
2. The Employee (or Dependent) was previously covered under another group health plan and the coverage was terminated due to a loss of eligibility; or
3. The Employee (or Dependent) was previously covered under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated due to a loss of eligibility.

In addition:

1. An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
2. A Child who has not attained age 26 and who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under PPACA.

<u>If the other coverage was COBRA coverage</u>: If COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), the COBRA coverage is treated as being exhausted as follows:

1. When an employer or other responsible party fails to remit premiums on a timely basis.

2. When the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available) for COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area.
3. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.
4. When the applicable time period of 18, 29 or 36 months has lapsed.

If the other coverage was not COBRA coverage: If coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan), a "loss of eligibility" includes but is not limited to any of the following: legal separation or divorce; cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the other health plan); death of an Employee; termination of employment; reduction in the number of hours of employment; or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "loss of eligibility" also includes a loss that occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "loss of eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicaid or CHIP: The Employee must request enrollment in writing within 60 days of the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of eligibility" does not include: A loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the other health plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

New Dependents (Employees) – If you are an Employee and acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, domestic partnership, birth, adoption, or Placement for Adoption. Coverage will be effective:

1. In the case of a marriage or domestic partnership, on the first day of the month concurrent with or following the marriage or domestic partnership;
2. In the case of a Dependent Child's birth, on the date of such birth;
3. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

New Dependents (Retirees) – If you are a retiree participating in the Plan as of the date of a marriage or domestic partnership, you may add (1) a new spouse or domestic partner, and/or (2) any newly eligible Dependent Children as a result of the marriage or domestic partnership. Coverage will be effective on the first day of the month concurrent with or following the marriage or domestic partnership.

If you are a retiree participating in the Plan as of the date you acquire a Dependent Child through birth, adoption, or Placement for Adoption, you may add (1) the new Dependent Child, and/or (2) an existing spouse or domestic partner. Coverage will be effective:

1. In the case of a Dependent Child's birth, on the date of such birth;
2. In the case of a Dependent Child's adoption or Placement for Adoption, on the date of such adoption or Placement for Adoption.

Notwithstanding the foregoing, benefits are provided for inpatient newborn care from the moment of birth, and enrollment is only required within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

A Child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order (QMSO) is eligible to be added to the Plan provided that you request enrollment within 31 days of the date of the QMSO. Coverage will be effective on the date of the QMSO.

If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility. Coverage will be effective on the date of eligibility.

Note: Participants who have attained age 19 who join the Plan during a special enrollment period will be subject to a 10-month Pre-existing Condition Waiting Period. The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of the employment status change.

Open Enrollment – Before the Plan Year begins, an Open Enrollment period shall be authorized to allow:

1. Employees and COBRA participants to change their coverage elections;
2. Employees and/or eligible Dependents to obtain new coverage; and
3. Employees, covered retirees, and COBRA participants to transfer to another AMHIC medical plan.

The Open Enrollment period shall be held before the Plan Year begins. Covered retirees are not permitted to add Dependents during Open Enrollment.

Re-Enrollment Provision – If an eligible Employee takes FMLA leave due to one or more of the reasons listed below and terminates his/her coverage in the Plan, he or she will be able to re-enroll in the Plan upon return to Active Employment at the conclusion of a period not to

exceed that defined by FMLA. This Employee will **not** be subject to the Pre-existing Condition Waiting Period that would otherwise be applicable to a termination from coverage in the Plan.

1. The birth of a son or daughter of the Employee and subsequent care for such son or daughter;
2. The placement of a son or daughter with the Employee for adoption or foster care;
3. Care for the Spouse, Domestic Partner, or a son, daughter, or parent of the Employee, if such Spouse, Domestic Partner, son, daughter, or parent has a serious health condition;
4. A serious health condition that makes the Employee unable to perform the functions of the position of such Employee;
5. Care for the Spouse, Domestic Partner, Child, parent, or next-of-kin of an Employee, if such Spouse, Domestic Partner, Child, parent, or next-of-kin is a service member and was injured during active duty; or
6. A "qualifying exigency" (as defined under Department of Labor regulations) arising out of the fact that the Employee's Spouse, Domestic Partner, son, daughter, or parent is a covered military member on “covered active duty”.

Enrollment forms can be obtained from your Employer’s Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume employment with your Employer within a period of time specified by the Employer, you will become eligible for reinstatement of coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if, prior to re-employment, you worked long enough to satisfy these waiting periods. A Certificate of Creditable Coverage will be required.

Leave of Absence (other than FMLA absence) – If you are on an approved leave of absence in accordance with your Employer’s written policy that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of continuation coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Eligibility Waiting Period or Pre-existing Condition Waiting Period if prior to the leave of absence you worked long enough to satisfy these waiting periods.

Changing Coverage – You may only change your election or your AMHIC medical plan selection during the Plan Year if you experience an “election change event.” Your election (employee, employee plus spouse, employee plus child(ren), or family coverage) is the type of coverage you selected when you initially enrolled. The following is a list of election change events:

1. Marital Status - Events that change your marital status, including marriage or domestic partnership, death of a Spouse or Domestic Partner, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including changes due to gaining eligibility status, birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change the employment status of the Employee or a Dependent, such as termination or commencement of employment, a reduction or increase in hours of employment, a strike or lockout, or a commencement or return from

an unpaid leave of absence, and that affect the Employee's or Dependent's eligibility for coverage under an employer-sponsored health plan;

4. A change that causes a Dependent to satisfy or cease to satisfy the eligibility requirements for coverage under the Plan or any other employer-sponsored health plan due to attainment of age, student status, marital status or any similar circumstances;
5. Residence or Worksite - A change in the place of residence or work that results in a move outside the applicable service area for you, your Spouse, or your Domestic Partner; or
6. Other election change events:

    a. Judgment, Decree or Order - If you, your Spouse or your Domestic Partner are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your Child, you may make a corresponding change in your election.
    b. Medicare/Medicaid Coverage - If you or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
    c. Eligibility for COBRA - If you or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
    d. Family and Medical Leave Act - If you take leave under FMLA, you may make other elections concerning group health coverage that are permitted by FMLA.
    e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
    f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
    g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Dependent makes to his/her benefit elections under a benefit plan offered by his/her employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Dependent's employer, and that the election change corresponds with that gain or loss of coverage.

You must contact your Employer's Human Resources Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your election change event.

Uniformed Service under USERRA – An Employee who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Employee fails to apply for reinstatement or to return to employment with the Employer. The Employee shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee, unless such Pre-existing Condition Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents – The Effective Date of coverage for an eligible Employee is the later of the following dates:

1. The effective date of this Plan;
2. The date the Employee's Eligibility Waiting Period concludes.

The Eligibility Waiting Period is the period from the date of hire until the first of the month immediately following the date of hire. If the Employee's hire date is on the first business day of the month, coverage is effective on the Employee's date of hire.

If you are not Actively at Work for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to Active Employment.

New Employees – New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. The effective date for Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, is the first day of the month following the date of eligibility. If the date of eligibility is on the first business day of the month, coverage is effective on that date.

New Dependents – If you acquire a new Dependent as a result of marriage, domestic partnership, birth, adoption, or Placement for Adoption, refer to the *New Dependents* subsections of *Section 4 – Membership Eligibility*.

If a previously ineligible individual subsequently meets the Dependent eligibility requirements, refer to the *Special Enrollment Period* subsection of *Section 4 – Membership Eligibility*.

If your current enrollment election already provides coverage for Dependents, coverage will be effective from the date of eligibility, upon receipt of a new enrollment application.

Changing Coverage – If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Pre-existing Condition Waiting Period – Participants must satisfy a 10-month Pre-existing

Condition Waiting Period from the Enrollment Date before becoming eligible to receive full benefits for Pre-existing Conditions. The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

This provision will not apply to pregnancy, nor to Participants who have not attained age 19 who are enrolled in the Plan. In addition, genetic information may not be considered a Pre-existing Condition unless there is a diagnosis of the condition related to that information.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

If an Employee or Dependent has not satisfied the Pre-existing Condition Waiting Period of the Employer's plan in effect immediately prior to the effective date of this Plan, credit will be given for the period of time which elapsed while the Participant was covered by the prior plan.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends – If your group is covered by provisions requiring continuation of group coverage under District of Columbia or federal law (COBRA), you and your covered Dependents who lose eligibility may be able to continue coverage for a limited period of time. Contact your group for more information. AMHIC offers COBRA coverage to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the termination will be effective on the last day of the month.

If a Participant does not elect or does not qualify for continuation of group coverage under District of Columbia law or COBRA continuation, coverage under this Certificate ends on the last day of the month.

For **any Participant, including Dependents**, coverage will terminate:

1. When the Employer gives us Written Notice of an Employee's termination or reduction of hours to a level that is ineligible to receive benefits. If the Employer fails to timely remove an ineligible Participant, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date;
2. Upon the Employee's or qualified retiree's death. If your benefits as an Employee or qualified retiree end due to your death, your surviving Dependents' coverage may continue under this Plan under COBRA (in the case of an Employee) or indefinitely (in the case of a qualified retiree);
3. When we do not receive the Premium payment on time;
4. When there is fraud or intentional misrepresentation of material fact on the part of the Participant;
5. When the Participant is no longer eligible for this group coverage under the terms of the Certificate;

6. On the date group coverage under this Certificate is discontinued for the entire group or for the Member's enrollment classification; or
7. Upon a proceeding in bankruptcy under Chapter 11 of the U.S. Code ("Chapter 11 bankruptcy") with respect to the Employer from whose employment a covered Employee retired at any time.

For a **Dependent**, coverage will terminate:

1. At the end of the last paid billing period for Dependent coverage;
2. When the Dependent no longer qualifies as a Dependent by definition; such a Dependent has the right to select COBRA continuation;
3. On the date of a final divorce decree or legal separation for a Spouse; such a Dependent has the right to select COBRA continuation;
4. When the Employee notifies us in writing to end coverage for a Dependent; or
5. When a Domestic Partnership is terminated; the Domestic Partner and his/her Children have the right to select COBRA continuation.

We will not refund Premiums paid on behalf of a Participant if:

1. We do not receive Written Notice of termination/change within 31 days of the effective date of termination/change; or
2. We have paid any claims on behalf of the Participant whose coverage has terminated.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A "qualified beneficiary" may continue coverage for a period of 18, 29 or 36 months at his/her own expense, pursuant to the provisions of COBRA, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". Along with an Employee, a Spouse, Domestic Partner, or Child is considered to be a qualifying beneficiary if coverage under the Plan is lost because of the qualifying event.

Eligibility – After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary as follows:

1. **Termination of Employment:** A qualified beneficiary may elect to continue coverage under this Plan for up to 18 months, if the beneficiary's eligibility ends due to one of the following qualifying events:

    a. The covered Employee is terminated from employment for reasons other than gross misconduct;
    b. The covered Employee's number of hours of employment is reduced below a certain level.

    "Gross misconduct" is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his/her work, provided such violation has harmed the Employer or other Employees or has been

repeated by the Employee despite a warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he or she is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security disability income benefits.

The qualified beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

a. The date of the Social Security Administration's disability determination;
b. The date on which the qualifying event occurs;
c. The date on which the qualified beneficiary loses coverage; or
d. The date on which the qualified beneficiary is informed by the Employer of the obligation to provide the disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days of the date that the qualified beneficiary is determined to be no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his/her eligibility ends due to any of the following qualifying events:

   a. The covered Employee dies;
   b. The covered Employee is divorced or legally separated;
   c. The covered Employee becomes eligible for and elects to receive Medicare benefits; or
   d. A Child ceases to be a Dependent (as defined by the Plan).

   The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse, Domestic Partner or Child is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or a Child's loss of Dependent status, as the case may be. The qualified beneficiary must provide written notification to the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later.

The qualified beneficiary may be required to complete a COBRA Qualifying Event Notification Form and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in

writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in forfeiture of COBRA coverage.

Note: Continuation coverage for Domestic Partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. In the case of an Employer which does offer continuation coverage, a Domestic Partner will be treated as a "qualified beneficiary" to the same extent as if the Domestic Partner were the Employee's Spouse. In addition, the Dependent Children of a covered Domestic Partner will be treated as "qualified beneficiaries" for these purposes to the same extent that Dependents of a Spouse would be so treated.

Multiple Event Extension: If a covered Dependent elects the 18-month continuation following an event shown in Part 1 and later becomes entitled to a 36-month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the COBRA Plan Administrator in writing**,** within 60 days of the occurrence of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

3. **Retirees and Bankruptcy –** A covered retiree of an Employer that declares Chapter 11 bankruptcy is eligible for continuation coverage if the retiree loses coverage within one year before or after the bankruptcy proceedings begin. A retiree may continue his/her COBRA coverage until the date of death. A Spouse, Domestic Partner or Dependent Child of the retiree is eligible for continuation coverage until the date of such person's death.

Election – A covered Employee can elect COBRA coverage for himself/herself and/or covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for a Dependent, such coverage may be elected by the Dependent. An election on behalf of a minor Child can be made by the Child's parent or Legal Guardian. No Spouse, Domestic Partner or Child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before the occurrence of any of the above qualifying events, provided however, that a child born to, adopted, or Placed for Adoption with a covered Employee during the period of COBRA coverage shall be considered a qualified beneficiary.

To continue coverage, the Employee or Dependent, hereinafter called a "continuee," affected by the qualifying event must make written election by the 60th day following the later of (a) the last

day of coverage; or (b) the date he/she is sent notice of the right to continue coverage. The 18- or 36-month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium – Within 45 days of the election date, the continuee must pay the required monthly Premium for the initial month of the COBRA coverage period. Thereafter, the due date for the monthly Premium is the first day of each coverage month, and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated Active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims – No claim will be payable under this COBRA provision until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination – Coverage under the COBRA provision will terminate on the earliest of the following:

1. The date on which the Employer ceases to provide a group health plan to Employees;
2. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
3. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
4. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
5. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
6. The end of the applicable 18-, 29- or 36-month period. Even if a second qualifying event occurs during the COBRA coverage period coverage will cease on the date that is36 months after the date of the original qualifying event, provided however, that coverage of retirees and their Dependents will continue as described above; or
7. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated Active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

HFS
4 North Park Drive, Suite 500
Hunt Valley, MD 21030
(888) 460-8005

CONTINUATION OPTION UNDER DISTRICT OF COLUMBIA LAW

The District of Columbia Continuation of Health Coverage Act of 2001 requires a DC small employer with fewer than 20 employees to extend health benefits to an Employee enrolled in the employer's health plan for a period of three months beyond the Employee's termination of coverage, unless the Employee is otherwise eligible for COBRA coverage. Because AMHIC offers COBRA to all groups regardless of size, an Employee is otherwise eligible for COBRA

coverage and therefore, this Certificate does not contain additional information about Continuation Coverage under such Act.

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by the Managed Care Vendor. The staff at the Managed Care Vendor are Physicians and registered nurses who monitor the use of your health care benefits to ensure that you and your family:

1. Receive the best medical care possible in the most appropriate health care setting;
2. Avoid unnecessary surgery and excess Hospital days;
3. Receive medical advice on questions you have regarding medical care; and
4. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the managed care program include:

1. Pre-certification of all:
   - Hospital or other facility Provider admissions, including inpatient psychiatric and obstetrical admissions;
   - Surgery required as the result of Morbid Obesity;
   - Dental services for treatment of cleft palate; and
   - Inpatient and outpatient organ transplant services and supplies;
2. Continued stay review of all hospitalizations;
3. Pre-Notification of all:
   - Home Health Care; and
   - Hospice.
4. Case management of potentially catastrophic cases.

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of the Managed Care Vendor. This may include, but is not limited to, the following reviews:

1. Cosmetic;
2. Experimental/Investigational; and
3. Outpatient services (for example, speech therapy, physical therapy, chiropractic services)

Otherwise, all Medical Necessity reviews will be performed by the Claims Administrator based on its medical policy guidelines.

HOW THE MANAGED CARE PROGRAM WORKS

PRE-CERTIFICATION:

If your Physician recommends that you or a Dependent be hospitalized, you must contact the Managed Care Vendor for assistance with the pre-certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require pre-certification. All other hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned hospitalization or within one business day after an emergency admission**. If you do not comply with the pre-certification requirement, benefits for Covered Services will be reduced by 50% up to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** To obtain admission pre-certification:

Call the Managed Care Vendor (InforMed): (866) 475-1256

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

Pre-certification may be initiated by you, a family member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 48 hours. At that time the Hospital will be advised of the number of approved days.

CONTINUED STAY REVIEW:

If necessary, you, a family member, your Physician, or a Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review. **If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.**

If your admission or request for extension is denied, you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in *Section 9 - How to File Health Care Claims.*

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission, benefits for Covered Services will be reduced by 50% to a maximum of $500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

PRE-NOTIFICATION

We recommend that you contact the Managed Care Vendor when your Physician requests that you have one of the following outpatient procedures or services:

1. Home Health Care;
2. Hospice.

You, a family member, or your Physician may call the Managed Care Vendor at: (866) 475-1256. Pre-notification is recommended for the initial procedure or service only. If the Managed Care Vendor is not notified, benefits may be denied.

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic Illness or accident, which usually results in a lengthy stay or multiple Hospital admissions. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and not Experimental/Investigational. Please see these definitions in *Section 3 - Definitions.* All benefit items listed in *Section 6 – Your Benefits* are subject to the provisions listed in *Section 5 - Cost Containment Features* and *Section 7 - General Limitations and Exclusions*; these sections explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Providers are based on the Allowed Benefit. Payments to Non-Network Providers for Medically Necessary ambulance services, Medical Emergencies, and for other exceptions listed in *Section 2 - Summary of Benefits* are based on the In-Network benefit level and the Allowed Benefit.
AMHIC shall have the discretionary authority to determine your eligibility and all benefits and terms contained in your Certificate. AMHIC's decision shall be final.

Hospital Benefits This portion of your coverage pays for services and supplies when they are provided by a Hospital or other facility Provider. We require certification prior to admission to a Hospital or other facility Provider (see *Section 5 - Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by Physicians or other professional Providers.

Accidental Injuries

Definition – Internal or external damage to the body caused by a source outside the body, requiring treatment for trauma rather than for Illness-related conditions (examples: strains, animal bites, burns, contusions, and abrasions).

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to ***Medical Care for General Conditions*** and ***Room Expenses and Ancillary Services***. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or other facility Provider is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under ***Medical Care for General Conditions***. Please refer to that section for additional information.

Outpatient: Medical care provided by a Physician or other professional Provider is covered. Please refer to ***Medical Care for General Conditions*** for additional information.

Limitations and Exclusions

Surgical Services – When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the ***Surgery*** subsection of this Certificate.

Acupuncture

Definition – Any service or supply administered by a licensed acupuncturist.

Medical-Surgical Benefits

Outpatient: Services or supplies administered by an acupuncturist who acts within the scope of licensure and according to the standards of acupuncture practice for the treatment of an Illness or accidental Injury. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Ambulance Services

Definition – a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Participant cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

1. Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
2. Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
3. When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the Hospital benefits limits shown above**.**

Limitations and Exclusions

1. **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's physical condition requires the services of an air ambulance. The Claims Administrator determines, on a case-by-case basis, based on its medical policy guidelines, when transport by ambulance is a covered benefit. If the Claims Administrator decides that ground ambulance services could have been used, then Payment will be limited to

ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.
2. **Other Transportation Services** – We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
3. **Patient Safety Requirement** – If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits

Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

1. **Acupuncture** — We cover only if Medically Necessary. See *Section 2 - Summary of Benefits* for amount of benefits and limitations.
2. **Hypnosis** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
4. **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
5. **Other —** The limitations and exclusions that apply to surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition – Blood expenses include the following items:

1. Charges for processing, transporting, handling, and administration;
2. Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or other facility Provider for processing, transporting, handling, and administration. We provide benefits as explained under ***Medical Care for General Conditions***. Covered expenses include charges made by a Hospital or other facility Provider for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

General – The limitations and exclusions that apply to surgery benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

1. **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
2. **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an inpatient or outpatient basis is covered.

Limitations and Exclusions

Chemotherapy and Radiation Therapy — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition – Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits

Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an Illness or accidental Injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.

2. **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
3. **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. See the ***Surgery*** subsection for covered benefits.

Cleft Palate and Cleft Lip

Definitions

1. **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
2. **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or other facility Provider when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

1. Speech therapy.
2. Otolaryngology treatment.
3. Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or other professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery (see the ***Surgery*** subsection).

Outpatient: We will allow benefits when provided by a Physician or other professional Provider for the following services: speech therapy; otolaryngology treatment; audiological assessments; orthodontic treatment; prosthodontic treatment; prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

1. **Benefit Eligibility** — Refer to *Section 4 - Membership Eligibility* for details on newborn coverage.
2. **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification request for such dental benefits to the Managed Care Vendor in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary, as defined in *Section 3 - Definitions*.
4. **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. The Physician treating your condition must submit a pre-certification

request for such surgical benefits to the Managed Care Vendor in advance of the date of services. For details, please refer to *Section 5 - Cost Containment Features.*

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the ***Surgery*** subsection.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental Injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five inpatient categories listed above, as well as for related services provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five inpatient categories of procedures referenced above when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your Physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical benefits when you meet **all** of the following criteria:

1. You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily Injuries outside the mouth or oral cavity;
2. Your Injury occurred on or after your Effective Date;
3. Treatment must be for Injuries to your sound natural teeth;
4. Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident;
5. The first services must be performed within 90 days after your accident;
6. Related services must be performed within one year after your accident; and
7. All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of Injuries from biting or chewing.

Limitations and Exclusions

1. **Facility Charges** — Inpatient and outpatient services at a Hospital or other facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
2. **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to *Section 5 - Cost Containment Features.*
3. **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
4. **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
5. **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
6. **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *Section 7 - General Limitations and Exclusions.*

Hemodialysis

Definition – the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered if you are treated in a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or other facility Provider. We allow benefits as explained in ***Medical Care for General Conditions***.

Outpatient: Services are covered for treatment in a Hospital, other facility Provider, or in your home.

Home Health Care

Definition – The following services provided by a certified Home Health Care Agency under a plan of care to eligible Participants in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; and physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits – We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency. Please refer to *Section 5 - Cost Containment Features.*

We allow benefits for up to 100 visits by a member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

1. Professional nursing services performed by a registered nurse or licensed practical nurse.
2. Physical therapy performed by a registered physical therapist.
3. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
4. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
5. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
6. Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
7. Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
8. Medical supplies furnished to the Participant by the Home Health Care Agency during visits for services.
9. Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

1. Prostheses and orthopedic appliances.
2. Rental or purchase of durable medical equipment (except hemodialysis equipment).
3. Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
4. Homemaker services for the patient only.

Limitations and Exclusions

1. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
3. **Non-Covered Services** — The following list of services are not home health care benefits:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.
    c. Services provided by a Physician.
    d. Services related to non-covered conditions and surgeries, as excluded in this Certificate.
    e. Services or supplies for personal comfort or convenience, other than homemaker services for the patient only.
    f. Services related to well-baby care.
    g. Food or housing.

4. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for home health care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*
5. **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as outpatient benefits as described under ***Mental Health, Alcohol or Drug Abuse Care***.
6. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition – an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his/her family.

Benefits – Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Participant's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Participant

with a life expectancy of six months or less, who alone or in conjunction with a family member has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Participant's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

1. Hospice day care services provided on a regularly scheduled basis in a Hospital, Skilled Nursing/Extended Care Facility, or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations.
2. Hospice home care services provided in the Participant's home to meet the Participant's physical requirements and/or to accommodate the Participant's maintenance or supportive needs.
3. Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse or licensed practical nurse.
4. Intermittent and 24-hour on-call social/counseling services, certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons.
5. Therapies, including physical, occupational, and speech.
6. Nutritional counseling by a nutritionist or dietitian.
7. Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Participant or family in dealing with a specified medical condition.
8. Family counseling related to the Participant's terminal condition.
9. Homemaker services (for the patient only) and Medically Necessary surgical and medical supplies.
10. Drugs and biologicals billed by the hospice Provider.
11. Oxygen and respiratory supplies.
12. Radiation therapy and chemotherapy.
13. Rental of durable medical equipment when billed by the hospice Provider.
14. Bereavement support services up to six visits for the family within 90 days following the death of the Participant.

Limitations and Exclusions

1. **Non-Covered Services** — The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

    a. Blood, blood plasma, or blood derivatives.
    b. Services provided by a Hospital.

c. Services related to non-covered conditions and surgeries, as excluded in this Certificate
d. Food services or meals other than dietary counseling.
e. Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care.
f. Private duty nursing.
g. Services by volunteers or people who do not regularly charge for their services.
h. Services by a licensed pastoral counselor to a member of his/her congregation.

2. **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
3. **Pre-Notification** — We recommend that the Physician treating your condition submit a pre-notification request to the Managed Care Vendor for hospice care benefits in advance of the date of service. For details, please refer to *Section 5 - Cost Containment Features.*

Laboratory, Pathology, X-ray, and Radiology Services

Definitions

1. **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services (Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs)).
2. **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or other facility Provider. Benefits are allowed as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*.**

Outpatient: Services are covered when provided by a Hospital or other facility Provider.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

1. **Non-Covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-Covered Service.
2. **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or other facility Provider are allowed only when our records show that the Physician has one of the following agreements with the facility:

a. The Hospital or other facility Provider will bill only for technical services such as charges for use of equipment; or
b. The Hospital or other facility Provider will not submit any charges for laboratory or X-ray services.

3. **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs.

Maternity and Newborn Care

Definitions

Maternity Services - services required by a Participant for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination (miscarriage) of pregnancy prior to full term.
4. Therapeutic or elective termination (abortion) of pregnancy prior to full term.
5. Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidaruni, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
6. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.
7. All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Participant receives from her obstetrician or nurse midwife.

Newborn Services include:

1. Routine Hospital nursery charges for a newborn well baby.
2. Routine Physician care of a newborn well baby in the Hospital after delivery.
3. Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
4. All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under ***Medical Care for General Conditions*****.** Routine Hospital nursery charges are also covered.

We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, the Plan provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not require the Provider to obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered expenses include: pre-natal medical care; a Hospital or other facility Provider's charges for use of labor, delivery, recovery, and nursery rooms; laboratory and X-ray services related to pre-natal or post-natal care. Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

1. Delivery services (post-natal medical care is included in the allowance for delivery services).
2. Professional component for interpretation of laboratory and X-ray results.
3. Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section (see Newborn Child Benefits below).

Outpatient: The following services are covered when billed by a Physician:

1. Pre-natal medical care.
2. Delivery services (post-natal medical care is included in the allowance for delivery services).
3. Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

1. **Artificial Conception** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Genetic Counseling** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one facility Provider to another, or when the mother is discharged from the facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, from the moment of birth. The baby must be enrolled as a Participant within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Please

refer to the *Effective Date of Coverage* subsection in *Section 4 - Membership Eligibility,* under *New Dependents***.**

Medical Care for General Conditions

Definition

Inpatient Medical Care — Non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient Medical Care — Non-surgical services provided in the Physician's office, the outpatient department of a Hospital or other facility Provider, or your home.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under ***Room Expenses and Ancillary Services***.

Outpatient: We will allow benefits for medical care provided by a Hospital or other facility Provider when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

1. A condition requiring **only** medical care; or
2. A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical nutrition therapy, for Participants who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or other facility Provider are also covered.

Limitations and Exclusions

1. **Biofeedback** — We will not Pay for biofeedback or related services.
2. **Birth Control** — Benefits are available for surgical sterilization and FDA-approved contraceptive drugs and devices (see ***Surgery*** and ***Preventive Services***).
3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
7. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*

8. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
9. **Growth Hormones** — We allow benefits for Medically Necessary growth hormones.
10. **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when Medically Necessary and prescribed by the patient's Physician.
11. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
12. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
14. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*
16. **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered.

Medical Emergencies

Definition – The sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy. We cover emergency services necessary to screen and stabilize a Participant without pre-certification if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that a Medical Emergency existed. To be eligible for this benefit, the Participant must seek emergency care within 48 hours after the Injury or onset of Illness. You are required to call the Managed Care Vendor (InforMed) at (866) 475-1256 within one business day after an emergency Hospital admission.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under ***Medical Care for General Conditions***. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or other facility Provider (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under ***Medical Care for General Conditions***.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician (see ***Medical Care for General Conditions***). Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

1. **Mental Health Conditions** — Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition

(e.g., depression secondary to diabetes or primary depression). These conditions are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

2. **Alcoholism or Drug Abuse Conditions** — Conditions requiring rehabilitation treatment from alcohol or drug abuse.
3. **Inpatient Care Charges** — Charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for mental health, alcoholism, or drug abuse care is also considered to be inpatient care. "Partial Hospitalization" is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
4. **Outpatient Care Charges** — Charges billed by a Physician, Hospital, Alcoholism Treatment Center, other professional Provider, or other facility Provider, for services provided in the Physician's or other professional Provider's office; the outpatient department of a Hospital, Alcoholism Treatment Center, other facility Provider; or your home.
5. **Pre-Certification** — You must contact the Managed Care Vendor prior to inpatient treatment for a mental health or substance abuse condition. Please call the Managed Care Vendor (InforMed) at: (866) 475-1256.

Benefits

Benefits are available for inpatient or outpatient care for Mental Health Conditions, Alcoholism, or Drug Abuse Conditions, including individual, family, and group therapy; psychiatric tests; detoxification; and expenses related to the diagnosis of such conditions.

Inpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services (see ***Room Expenses and Ancillary Services***). "Partial Hospitalization" benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to *Section 2 - Summary of Benefits* for your Deductible and Coinsurance amounts for this benefit.

Limitations and Exclusions

1. **Biofeedback** — See this heading under *Section 7 - General Limitations and Exclusions*.
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions*.
3. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Domiciliary Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Duration of Care** — We will only Pay for services that can be expected to improve your mental health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or the Claims Administrator.
6. **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *Section 7 - General Limitations and Exclusions*.
7. **Private Room Expenses** — Under no circumstances will private room benefits be covered for treatment of mental health, alcoholism, or drug abuse. See this heading under *Section 7 - General Limitations and Exclusions*.

8. **Professional Services — Mental Health** — Professional services for mental health must be performed by a Physician, licensed clinical psychologist, or other professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
9. **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or other professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
10. **Therapies** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Transfers** — See this heading under *Section 7 - General Limitations and Exclusions.*

Organ Transplants

Definition – A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Covered Services – Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

1. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
2. When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
3. When the donor is covered under this Plan, the Plan will pay the donor's covered expenses related to the transplant, provided the recipient is also covered under this Plan. Covered expenses incurred by each person will be considered separately for each person.
4. Expenses incurred by the donor who is not covered under this Plan, according to eligibility requirements, will be covered expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan.
5. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
6. Charges incurred for follow-up care, including immunosuppressant therapy.

Travel Allowance: While traveling to and from the Transplant Program Provider, and if the Transplant Program Provider is located 50 or more miles from the recipient's home, the following benefits are covered expenses:

1. Transportation is limited to a maximum of the cost of a round-trip coach airfare to the Transplant Program Provider for you and your travel companion;

2. Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel;
3. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should you be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
4. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan;
5. Hotel accommodations (limited to one room, double occupancy) up to $200 per day at hotels should a donor who is not covered under this Plan be released to an outpatient facility for Medically Necessary post-surgical care from the Transplant Program Provider;
6. Daily meals and other reasonable and necessary services or supplies for you, your travel companion, or a donor up to an allowance of $75 per person per day;
7. The maximum payment will not exceed $10,000 per transplant for all combined travel expenses incurred by you, your travel companion, or a donor. The Deductible will not apply toward the Travel Allowance benefit.

The Transplant Program Provider is the Physician performing the transplant and/or the Hospital in which the transplant is performed.

Organ transplant procedures, including complications from any such procedure, services or supplies related to any such procedure, such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, **except** for the following procedures:

1. Heart; combined heart and lung; single lung; double lung; lobar lung; kidney; kidney/pancreas; pancreas; cornea; liver; bone; small bowel in pediatric patients; small bowel/liver; multivisceral; skin (for grafting or for any other Medically Necessary purposes);

2. Autologous bone marrow for:

    a. Non-Hodgkin's lymphoma;
    b. Hodgkin's lymphoma;
    c. Primitive neuroectodermal tumors (PNET);
    d. Acute lymphocytic leukemia in first or subsequent remission;
    e. Acute non-lymphocytic leukemia in first or subsequent remission;
    b. Germ cell tumors;
    c. Multiple myeloma;
    d. Amyloidosis;
    e. Acute myelogenous leukemia;
    f. Recurrent or refractory Ewing’s sarcoma

3. Allogeneic bone marrow for:

    a. Aplastic anemia;
    b. Acute leukemia;
    c. Severe combined immunodeficiency;
    d. Wiskott-Aldrich syndrome;
    e. Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
    f. Chronic myelogenous leukemia (CML);

g. Neuroblastoma Stage III or IV in children;
h. Homozygous beta thalassemia (thalassemia major);
i. Hodgkin's lymphoma;
j. Non-Hodgkin's lymphoma;
k. Myelodysplastic syndromes;
l. Lysosomal storage disorders (mucopolysaccharidosis, Gaucher's disease, Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome, mucolipidosis, lipidosis, and metachromatic leukodystrophy);
m. Multiple myeloma;
n. Sickle-cell anemia;
o. Myeloproliferative disorders.

Pre-Certification — The Provider is responsible for ensuring that pre-certification is received from the Managed Care Vendor before scheduling a pre-transplant evaluation. A case manager will be assigned to the Participant and must be contacted with the results of the evaluation. For details, please refer to *Section 5 - Cost Containment Features.*

Inpatient: The case manager will work with the Participant's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by a Plan-approved Hospital or other facility Provider.

Outpatient: Services provided by an approved Hospital or other facility Provider are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when pre-certified.

Limitations and Exclusions

1. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Donor Expenses** – The services and medical expenses incurred by a donor (except as specified above) as a result of the transplant procedure are not covered.
4. **Donor Screening** – Donor screening of the general population is not covered.
5. **Donor Specification** — We will only cover an organ transplant from a human donor. For example, transplant of a non-human animal organ or artificial organ is not covered.
6. **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
7. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Lost Wages** – Reimbursement of any wages lost by you, your travel companion, or a donor are not covered.
9. **Medicare-Eligible Participants** — Participants who are now eligible for, or who are anticipating receiving eligibility for, Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
10. **Personal Expenses** – Personal expenses incurred for the maintenance of your residence, a travel companion's residence, or a donor's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges.
11. **Pre-Certification** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-certified by the Managed Care Vendor.

12. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
13. **Travel** – Travel, lodging, and other charges for your travel companion are not covered, other than to accompany you to and from the Transplant Program Provider and to remain in the immediate area during all or a portion of the duration of your treatment plan. Charges in connection with the Travel Allowance that are not related to your or a donor's travel to and from the Transplant Program Provider are not covered. Charges for the repair or maintenance of a motor vehicle are not covered.

Preventive Services

Medical-Surgical Benefits

In compliance with Section 2713 of PPACA, benefits are covered for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations are covered that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive Services covered under PPACA may be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

With respect to women, additional preventive care and screenings are covered, as provided for in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
www.healthcare.gov/what-are-my-preventive-care-benefits.

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definitions

1. **Occupational Therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury in order to live independently.

2. **Physical Therapy** — The use of physical agents to treat disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
3. **Speech Therapy (also called Speech Pathology)** — Services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits

Inpatient and Outpatient: When provided by a Hospital or other facility Provider, the following types of therapy are covered as set forth under ***Medical Care for General Conditions***:

1. Occupational therapy;
2. Physical therapy;
3. Speech therapy.

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Cardiac Rehabilitation programs, excluding cardiac education classes.
2. Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy.
3. Physical therapy performed by a Physician or registered physical therapist.
4. Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.
5. Benefits for Participants who have attained the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and the Plan will result in significant improvement with treatment and would not normally be expected to improve without intervention.
6. Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of Children who have not attained age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

1. **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
2. **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:

    a. Learning disorders;
    b. Stuttering, at any age;
    c. Behavioral disorders;

d. Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Participant's Provider, neurologist, or other related specialist;
e. Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions);
f. Deafness;
g. Disorders of cognitive etiology;
h. Sensory integration therapy.

3. **Habilitative Therapy** — We will not Pay for habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions

1. **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and other facility Providers bill for and regularly make available for the treatment of the Participant's condition. Such services include, but are not limited to:

    a. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
    b. Intensive and coronary care units.
    c. Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
    d. Dressings and supplies, sterile trays, casts, and splints.
    e. Diagnostic and therapeutic services.
    f. Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).

2. **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
3. **Skilled Nursing/Extended Care Facility** — a licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under ***Medical Care for General Conditions*** and ***Mental Health, Alcohol, or Drug Abuse Care*****.** An inpatient Hospital admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Skilled Nursing/Extended Care Facility Admissions: For Covered Services, you must be admitted to a Skilled Nursing/Extended Care Facility within 14 days of a Hospital stay that lasted three or more days. Coverage is available to each Participant for up to 100 days per Plan Year in a Skilled Nursing/Extended Care Facility. Covered Services include semiprivate room expenses and Ancillary Services. Skilled Nursing/Extended Care Facility admission requires the recommendation of a Physician and pre-certification by the Managed Care Vendor.

Outpatient: Ancillary services billed by a Hospital or other facility Provider are covered. For additional outpatient Hospital benefits, see the following sections:

1. ***Hemodialysis;***
2. ***Laboratory, Pathology, X-ray, and Radiology Services;***
3. ***Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech.***

Limitations and Exclusions:

1. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
2. **Discharge Day Expense** — See this heading under *Section 7 - General Limitations and Exclusions.*
3. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see ***Mental Health, Alcoholism, or Drug Abuse Care.***
5. **Personal or Convenience Items** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

1. **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Supplies, Equipment, and Appliances

Definitions

1. **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.

2. **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
3. **Prosthesis** — any device that replaces all or part of a missing body organ or body part.
4. **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under ***Medical Care for General Conditions***:

1. Medical supplies used while you are in the Hospital.
2. Use of durable medical equipment owned by the Hospital while you are hospitalized.

Outpatient: Covered expenses include medical supplies used during covered outpatient visits (see ***Medical Care for General Conditions***).

Medical-Surgical Benefits

The following medical supplies are covered:

1. Medical supplies not available from a Pharmacy, including but not limited to:

    a. Colostomy bags and other supplies required for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

    NOTE: Some diabetic supplies are covered under the ***Prescription Drugs and Medicines*** section of this Certificate. Coverage is not provided for such diabetic supplies under both the Prescription Drugs and Medicine Section and this section of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the Network Pharmacy.

2. We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
3. The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:

    a. Artificial arms, legs, or eyes.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Maxillofacial prostheses.
    e. Cervical collars.
    f. Surgical implants.
    g. Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

4. Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription.

5. We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient).

Limitations and Exclusions

1. **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Allowed Benefit for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and fashion eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
2. **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
3. **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury.
4. **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain.
5. **Medical Supplies** — Items that do not serve a useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
6. **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Participant's condition.
7. **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items.
8. **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of Medical Necessity.

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under ***Medical Care for General Conditions*****.**

Outpatient: Services provided by a Hospital or other facility Provider are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

Note: In compliance with the Women's Health and Cancer Rights Act, benefits include reconstruction of a breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

The following guidelines apply to surgical procedures:

1. **Assistant Surgeon Fees** – The amount eligible will be based on 20% of the Allowed Benefit for the covered surgical procedure.
2. **Co-Surgery Fees** – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Allowed Benefit for that procedure.
3. **Multiple Surgical Procedures** – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Allowed Benefit and all other eligible procedures will be based on 50% of the Allowed Benefit.

Limitations and Exclusions

1. **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or other facility Provider.
2. **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:

    a. When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
    b. When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered.

3. **Convalescent Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
4. **Cosmetic Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
5. **Custodial Care** — See this heading under *Section 7 - General Limitations and Exclusions.*
6. **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see ***Dental Services.***

7. **Diagnostic Admissions** — See this heading under *Section 7 - General Limitations and Exclusions.*
8. **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or other facility Provider requires such services, assistant surgery benefits are not allowed.
9. **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical benefits for the assistant surgery.
10. **Isolation Charges** — See this heading under *Section 7 - General Limitations and Exclusions.*
11. **Obesity and Weight Loss** — We will Pay for surgery required as the result of Morbid Obesity, including related pre- and post-surgical office visits, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime. For details, please see ***Morbid Obesity*** under *Section 7 - General Limitations and Exclusions.*
12. **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Participant's Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. This benefit requires pre-certification by the Managed Care Vendor.
13. **Other** — The limitations and exclusions that apply to surgery benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
14. **Private Room Expenses** — See this heading under *Section 7 - General Limitations and Exclusions.*
15. **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
16. **Restorative or Reconstructive Surgery** — See this heading under *Section 7 - General Limitations and Exclusions.*
17. **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
18. **Sex-Change Operations** — See this heading under *Section 7 - General Limitations and Exclusions.*
19. **Sterilization** — We will allow benefits for surgical sterilization (female sterilization is covered under the ***Preventive Services*** section). Reversals of sterilization procedures are not covered.
20. **Temporomandibular Joint Surgery or Therapy** — See this heading under *Section 7 - General Limitations and Exclusion.*
21. **Vision** — See this heading under *Section 7 - General Limitations and Exclusions.*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for Generic, Formulary Brand Name and non-Formulary Brand Name prescription drugs under a three-tier Prescription Drug Plan. Coinsurance amounts are as follows:

PRESCRIPTION DRUG PLAN	Retail (30-day supply)	Mail Order (90-day supply)
All prescription expenses are subject to the Deductible, except Preventive Services Drugs. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Non-Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to Preventive Services, in compliance with the Patient Protection and Affordable Care Act of 2010**	No Charge	
** A description of Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		
FDA-Approved Generic Drugs and Over-the-Counter Drugs, Devices, and Supplies related to Women's Preventive Services, including FDA-approved contraceptive methods, in compliance with the Patient Protection and Affordable Care Act of 2010***	No Charge	
*** A description of Women's Preventive Services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits		

NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug and you purchase a Brand Name drug when a Generic drug is available, you will pay the Generic Coinsurance plus the difference in price between the Brand Name drug and the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written" on the prescription.

Generic versions of Brand Name drugs are reviewed and approved by the FDA. Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand Name drug. If you choose the Generic drug, you will always pay the lowest cost.

The Participant should discuss the prescription alternatives with his/her Physician to determine if a lower cost alternative is available and appropriate. The Participant and the Physician should determine the treatment plan that is most appropriate. In some cases, this may mean the patient will pay a higher cost.

Over-the-Counter Drugs and Devices related to Preventive Services (including Women's Preventive Services) – PPACA requires that the Plan provide benefits for a comprehensive list of Preventive Services, including Women's Preventive Services. Included in this list are several over-the-counter (OTC) drugs, plus FDA-approved generic and OTC birth control medications and devices. If your Physician recommends that you take one of these drugs or use one of these devices, benefits will be provided under this Prescription Drug Plan. You must obtain a prescription from your Physician for the generic or OTC drug or device and present it to the Pharmacy. The Pharmacy will fill your prescription with no Coinsurance. Information regarding Preventive Services, including Women's Preventive Services, can be found here:

www.healthcare.gov/what-are-my-preventive-care-benefits

Express Scripts - The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide, and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts online at www.express-scripts.com or by calling Customer Service at (800) 451-6245 for a list of Network Pharmacies. You can also call the Claims Administrator Customer Service at (877) 889-2478.

Step Therapy Program – In Step Therapy, drugs are grouped into categories, based on cost effectiveness. Front-line drugs (Step 1) are Generic drugs proven safe, effective and affordable. Back-up drugs are lower-cost Brand Name drugs (Step 2) and higher-cost Brand Name drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Under the Step Therapy program, Physicians will be asked to request "Step 1" medications the first time they prescribe drugs for Participants in a covered treatment category. If your Physician decides you need a different drug for medical reasons, he or she must call Express Scripts to request a Prior Authorization. If the request for Prior Authorization is approved, you will pay the higher cost for the back-up drug. If you choose to get your written prescription filled as is, you will pay the full cost of the medication, and the drug will not be covered by the Prescription Drug Plan. Step Therapy includes, but is not limited to, the following drug categories:

1. Proton pump inhibitors;
2. SSRIs;
3. NSAIDs;
4. Cox-II Inhibitors for pain and arthritis;
5. HMG (cholesterol).

You can find out whether your prescriptions are part of the Step Therapy program by calling Express Scripts Customer Service at (800) 451-6245.

Prior Authorization - Certain drugs in the Prescription Drug Plan require Prior Authorization from Express Scripts before they can be considered for benefits. To obtain Prior Authorization, your Physician must contact Express Scripts when prescribing one of the following drugs:

1. Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but could also be used for cosmetic purposes;
2. A drug listed on the Prior Authorization List.

Note: The Prior Authorization List is subject to change. To obtain a copy of the current list, go to the Express Scripts website (www.express-scripts.com) and sign on as a Member.

Please request that your Physician contact Express Scripts before prescribing a drug that is listed on the Prior Authorization List. If the prescription drug is approved by Express Scripts, you will pay the applicable Coinsurance. If the drug is not approved, you will be responsible for the full cost. To obtain Prior Authorization, please call Express Scripts Customer Service at (800) 451-6245.

Select Home Delivery Program – After two prescription fills of a Maintenance Prescription Drug at a retail Network Pharmacy, the Select Home Delivery Program encourages participants to obtain these medications through the Mail Service Prescription Drug Program. A participant may opt out of the Select Home Delivery Program completely or for specific drugs. Please call Express Scripts Customer Service at (800) 451-6245 for details.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigational in order to be a Covered Service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before Express Scripts can determine Medical Necessity. Express Scripts may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered Services will be limited based on Medical Necessity, quantity limits established by Express Scripts, or utilization guidelines. Prior Authorization may be required for certain drugs.

Covered Services include:

1. Legend drugs, including self-administered injectable drugs.
2. Injectable insulin and syringes used for administration of insulin.
3. Anorexiants for Participants under age 18.
4. Prescribed oral contraceptive and contraceptive devices.
5. Prescribed pre-natal vitamins.
6. Prescribed Nicorette gum or patches.
7. Tretinoin (sold under such brand names as Retin-A®) prescribed for Participants up to the age of 30. Prior Authorization is required for patients age 30 or older, and the drug must be prescribed for acne treatment only.
8. Certain supplies, equipment or appliances obtained through the Mail Service Prescription Drug Program or from a Network Pharmacy (such as those for diabetes and asthma). Contact Express Scripts to determine approved covered supplies. Prior Authorization is required. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or the Mail Service Prescription Drug Program, they may be covered as medical supplies, durable medical equipment and appliances under other sections of this Certificate, outside the Prescription Drug Program.
9. Prescription drugs, approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra), are limited to six pills per month.

Off-label Drugs – When the FDA is satisfied that a drug works and is safe, the agency and the drug maker create a drug label. A drug label is a report of very specific information. The FDA-approved drug label is made available to health professionals, who dispense and prescribe the drug. The drug label contains information about the drug, including the approved doses and how it is to be given to treat the medical condition for which it was approved. When a drug is used in a different way than described in the FDA-approved label, it is said to be an “off-label” use. This can mean that the drug is:

1. used for a different disease or medical condition;

2. given in a different way (such as a different route); or
3. given in a different dose than in the approved label.

For example, when a chemotherapy drug is approved for treating one type of cancer but is used to treat a different cancer, it is considered off-label use.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

1. The drug is approved by the FDA.
2. The prescribed drug use is supported by one of the following standard reference sources:

    a. DRUGDEX;
    b. American Hospital Formulary Service Drug Information;
    c. Medicare-approved compendia; or
    d. Scientific evidence derived from well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.

3. The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Limitations and Exclusions

1. **Anorexiants** — Anorexiants for Participants age 18 and over are not covered.
2. **Appetite Suppressants** — Drugs prescribed for weight control or appetite suppression are not covered.
3. **Cosmetic Services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered.
4. **FDA Approval** — Any New FDA-Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology receives FDA New Drug Approval or other applicable FDA approval is not covered. Express Scripts may, at its sole discretion, waive this exclusion in whole or in part for a specific New FDA-Approved Drug Product or Technology.
5. **Fertility Drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered.
6. **Formulas/Vitamins** — Special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders; see Covered Services, above, for benefits) are not covered. Vitamins, folic acid, or minerals, except for Legend prenatal vitamins are not covered.
7. **Growth Hormones** — Prior Authorization in writing for growth hormone therapy is required in advance of the date of service. Please contact Express Scripts Customer Service at (800) 451-6245 for additional information.
8. **Other Non-Covered Items** — Benefits are not allowed for:

    a. Delivery charges;
    b. Charges for the administration of any drug;

c. Drugs consumed at the time and place where dispensed or where the prescription is issued, including but not limited to samples provided by a Physician;
d. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
e. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the Prescription Drug Plan;
f. Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use);
g. Drugs and supplies unless specifically included as a covered drug;
h. Medication or supplies when benefits are available under a personal injury protection contract or no-fault motor vehicle insurance; or
i. Medication or supplies where cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Participant.

9. **Prescriptions** — Non-prescription drugs and OTC drugs, including herbal or homeopathic preparations, and prescription drugs that have OTC bio-equivalents are not covered even if written as a prescription, except as specified in this Certificate. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin, OTC drugs and devices related to Preventive Services, and the drugs listed in the Over-the-Counter Option section, as described above. Some prescription drugs may not be covered even if you receive a prescription from your Physician.
10. **Prior Authorization** — Prescription drugs that have not been previously authorized by Express Scripts are not covered drugs eligible for reimbursement, unless otherwise specified in this Certificate.
11. **Quantity** — Prescription drugs dispensed in quantities that exceed the applicable limits established by Express Scripts, at its sole discretion, are not covered.
12. **Refills** — Refills in excess of the number contained in the prescription or refills submitted one year from the date of such prescription are not covered.
13. **Smoking Cessation** — Non-prescribed Nicorette, nicotine patches, other drugs containing nicotine, or other smoking deterrent medications are not covered, except as specified under ***Preventive Services***.
14. **Travel** — Prescription drugs purchased overseas or dispensed for the purpose of international travel are not covered.
15. **Tretinoin (sold under such brand names as Retin-A®) for Participants Age 30 and Older** – Prescriptions for Participants age 30 and older must be accompanied by a Prior Authorization and prescribed for acne treatment in order to be covered.

How To File a Claim for Prescription Drugs

When you present your Identification Card to a Network Pharmacy, your cost for a prescription or a refill will be the prescription drug Coinsurance as indicated above. For Maintenance Prescription Drugs, you can obtain a larger quantity (90-day supply) by using the Mail Service Prescription Drug Program described below, saving you trips to the Pharmacy and prescription expenses.

Network Pharmacies - Many Pharmacies participate in the Prescription Drug Plan. When you go to a Network Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your Coinsurance and fill your prescription(s).

Non-Network Pharmacies or Network Pharmacies When the Participant Does Not Use the Identification Card - You must submit a claim directly to the Prescription Drug Plan when you purchase a prescription from a Non-Network Pharmacy or do not use your Identification Card at a Network Pharmacy. The Prescription Drug Plan will reimburse you based on the amount typically paid to Network Pharmacies for the same drug, less your Coinsurance. The price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts Customer Service at (800) 451-6245 or visit its website at www.express-scripts.com and enter your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for Maintenance Prescription Drugs that require a prescription by law to purchase and insulin. The maximum quantity which can be claimed is a 90-day supply, which is more than may be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes prescription costs. Please visit www.express-scripts.com to order these drugs online, or call Express Scripts Customer Service at (800) 451-6245 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions

1. **Brand Name drug** — The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.
2. **Generic drug** — A drug that has been determined by the FDA to be bioequivalent to Brand Name drugs and that is not manufactured or marketed under a registered trade name or trademark. Generic drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name drug. On average, Generic drugs cost about half as much as the counterpart Brand Name drugs.
3. **Formulary** – A list of FDA-approved prescription drugs and supplies developed by the Express Scripts Pharmacy and Therapeutics Committee, representing the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. The Formulary is used as a guide for determining the amount that you pay for each prescription, with drugs listed on the Formulary typically available at a lower cost to you. To access the Express Scripts Formulary, your Physician can log on to www.express-scripts.com.
4. **Maintenance Prescription Drug** — Prescription drugs that are used on a continuing basis for the treatment of a chronic Illness, such as heart disease, high blood pressure, arthritis, or diabetes.
5. **Multisource Brand drug** – A Brand Name drug that has a Generic alternative.
6. **Network Pharmacy** — A Pharmacy that participates in the network that the prescription benefits manager, Express Scripts, has contracted to provide prescription drug benefits to AMHIC's Members. Contact Express Scripts or visit their website at www.express-scripts.com to determine if a Pharmacy participates.
7. **Non-Network Pharmacy** — Any Pharmacy that does not participate in the network that Express Scripts has contracted to provide prescription drug benefits to AMHIC's

Members. Charges incurred at Non-Network Pharmacies will be reimbursed based on the amount typically paid to Network Pharmacies for the same drug, minus your Coinsurance.

8. **New FDA-Approved Drug Product or Technology** — The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. New FDA-Approved Drug Product or Technology does not include:

    a. New formulations;
    b. A new dosage form or new formulation of an active ingredient already on the market;
    c. An already marketed drug product but new manufacturer;
    d. A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
    e. An already marketed drug product but new use;
    f. A new use for a drug product already marketed by the same or a different firm; or
    g. A newly introduced Generic drug.

9. **Pharmacy** — An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's prescription.
10. **Pharmacy and Therapeutics Committee** — A committee of Physicians and pharmacists who review literature and studies that address safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
11. **Legend drug** — A medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Legend drugs. Insulin is considered a Legend drug under this Certificate.
12. **Prior Authorization** — The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain Prior Authorization, please request that your Physician contact Express Scripts before prescribing a drug that requires Prior Authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable Coinsurance. If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please call Customer Service at (800) 451-6245.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** benefits described in this Certificate. **Benefits for the following services, supplies, situations, or related expenses are excluded unless otherwise covered as described below:**

Alcohol-related − Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Participants other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, test tube fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable no-fault insurance laws. See *Section 11 - Automobile No-Fault Insurance Provisions* for further information.

Autologous Hematopoietic − Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental/Investigational.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Controlled Substances – Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from another person's voluntary use or condition of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical condition (including both physical and mental health conditions).

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by the medical policy guidelines of the Claims Administrator. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. The Managed Care Vendor must give written pre-certification for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Participant in the activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in a facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Participant's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health benefit plan, then total benefit Payments will not be more than 100 percent of total covered expenses. See *Section 13 - Duplicate Coverage and Coordination of Benefits* for further information.

Experimental / Investigational Procedures — Any treatment, procedure, drug or device that has been found by the Plan to be Experimental/Investigational, as defined in *Section 3 – Definitions,* is not covered. The determination that a service is Experimental/Investigational can be made by the Plan either before or after the service is rendered.

Family Counseling — Charges for family counseling are not covered, except as specified under ***Hospice Care*** in *Section 6 - Your Benefits.*

Family Therapy — Charges for family therapy are not covered, except as specified under ***Mental Health, Alcohol, or Drug Abuse Care*** in *Section 6 - Your Benefits*.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to genetic testing for inherited susceptibility to a medical condition or discussion of family history or test results to determine the gender or physical characteristics of an unborn child. Medically Necessary genetic testing to evaluate risks for certain types of conditions may be covered based on medical policy guidelines of the Claims Administrator and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected disability are not covered.

Hair Loss — Coverage for wigs, or artificial hairpieces is limited to one per Participant per calendar year except for the treatment of a serious medical condition. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or Homeopathic Medicine – Services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Illegal Acts − For services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions.)

Isolation Charges — We will only Pay private room expenses under your Hospital benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Participant has received a professional or courtesy discount, or for services provided by the Participant upon him/herself, or by a family member.

Massage Therapy – Massage therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary, as defined in *Section 3 - Definitions.* Our decision as to whether a service or supply is Medically Necessary is based on medical policy guidelines of the Claims Administrator regarding approved and generally accepted medical or surgical practice. **The fact that a Provider may prescribe, order, recommend, or approve a service does not, in and of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military – Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Morbid Obesity – We will Pay for surgery required as the result of Morbid Obesity, as defined in *Section 3 – Definitions*, **only if pre-certified by the Managed Care Vendor.** Such surgery is limited to once per Participant, per Lifetime.

Non-Covered Services — Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (for example, non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy/Formulas — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother's milk or diets, even if the substance is prescribed by a Physician and

the sole source of nutrition, are not covered except for metabolic formulas for treatment of inherited enzymatic disorders and Legend prenatal vitamins.

Personal Comfort or Convenience — Services and supplies used primarily for an individual's personal comfort or convenience that are not related to the treatment of a medical condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post-Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the hospitalization, services, or supplies were made necessary by an accident, Illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — The Plan will **not** pay more than $500 per Participant for Covered Services related to a Pre-existing Condition during the Pre-existing Condition Waiting Period.

The Pre-existing Condition Waiting Period will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Creditable Coverage may be used for this purpose.

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Waiting Period.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered expenses are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of mental health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Relative Giving Services – Services or supplies rendered by the Employee, Employee's Spouse or Domestic Partner, and the Children, brothers, sisters, parents, or grandparents of either the Employee or Employee's Spouse or Domestic Partner.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect. A congenital defect or anomaly is defined as existing at or dating from birth. Disorders due to inappropriate growth are not considered congenital.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical Illness, subject to the same Deductible and Coinsurance. If a Participant chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Managed Care Vendor must give written pre-certification for such benefits in advance of the date of services.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Except for prescription drugs intended for the treatment of sexual dysfunction, services and supplies for the treatment of sexual dysfunction are not covered. See ***Prescription Drugs and Medicines*** under *Section 6 - Your Benefits* for further information.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Unless otherwise specifically covered, therapies and self-help programs are excluded from coverage under this Certificate. Such therapies and programs include, but are not limited to the following:

1. Recreational, sex, primal scream, and sleep therapies.
2. Self-help, stress management, smoking cessation, and weight loss programs, except as specified under ***Preventive Services***.
3. Transactional analysis, encounter groups, and transcendental meditation (TM).
4. Sensitivity or assertiveness training.
5. Religious or marital counseling.
6. Holistic medicine and other wellness programs.
7. Educational programs such as behavior modification and classes for a specific condition, such as arthritis class.
8. Myotherapy or massage therapy and rolfing.
9. Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. See *Section 12 - Third-Party Liability — Subrogation* for further information.

Transfers — The transfer of a patient from one Physician to another Physician for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Other than travel expenses for you and a travel companion in connection with an organ transplant, your travel expenses are not covered. See ***Organ Transplants*** under *Section 7 – General Limitations and Exclusions*. Travel expenses for your Physician or other health care professionals are not covered.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Participant from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Weekend Admissions − Charges for any non-emergency inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week are not covered. Charges for a Sunday admission will be eligible only when procedures are scheduled to be performed early Monday morning.

Workers' Compensation Services or Supplies Resulting From a Work-Related Illness or Injury – See *Section 10 - Workers' Compensation* for further information.

SECTION 8

GENERAL PROVISIONS

Catastrophic Events – In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan – AMHIC may modify or amend the Plan from time to time at its sole discretion. Any amendment/modification of the Plan shall be in writing and signed by an officer of AMHIC pursuant to authorization by AMHIC's Board of Directors. The amendments or modifications which affect Members will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by AMHIC with the bargaining representatives of any employees. If any amendment includes a change that constitutes a material reduction in services or benefits, Members for whom that change is material will be informed of the change within 60 days of adoption of the change.

Contracting Entity – The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, a District of Columbia corporation licensed as a captive insurance company . The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability – AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Participant by any facility or professional Provider, and is not liable for any loss or Injury caused by any Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information – Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

1. A third party, such as your Employer requests medical information in connection with utilization summaries or review of claims, if such third party funds all or a part of the cost of your claims.
2. Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
3. The Plan receives a judicial or administrative subpoena for such information.
4. The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
5. The information is required for:

    a. Workers' Compensation proceedings;
    b. No-fault auto insurance cases;
    c. Third-party liability (subrogation) proceedings; and
    d. Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Participant – We reserve the right and opportunity to request a medical examination of a Participant when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers – On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance, Securities and Banking (DISB).

Member's Legal Expense Obligations – You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable – This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Notices – All notices to the Member are considered to be delivered to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either the Member at the latest address appearing on our membership records or to the Member's Employer.

Paragraph Headings – The paragraph and section headings used throughout this Certificate are for reference only. They are not to be used by themselves for interpreting the provisions of the Certificate.

Payments Made in Error – If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments Made in Error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments Made in Error.

Release of Medically-Related Information – You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the

provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Reserve Funds – No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

NETWORK PROVIDERS

Before you use a Provider listed in the network directory, call the Provider or the network to verify that the Provider is still a Network Provider. Simply present your Identification Card at the time you receive services. The Network Provider will file a claim with the network and will be directly reimbursed for the services you receive.

BLUECARD PROGRAM – OUT-OF-AREA SERVICES

Claims for services rendered outside of the CareFirst Administrators local service area will be handled by the Host Blue.

NON-NETWORK PROVIDERS WITHIN THE CAREFIRST ADMINISTRATORS LOCAL SERVICE AREA

Medical Services – Reimbursement of medical expenses provided by Non-Network Providers is handled by the Claims Administrator. Claims for benefits may be filed by a Provider or by the Member. Payment will be made by the Claims Administrator either to the Provider or the Member.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and include the following information on the bill:

1. Employee name;
2. Employee's identification number;
3. Patient name;
4. Employer name or group number;
5. Provider's tax ID number (TIN);
6. Procedure code;
7. Diagnosis code;
8. Date of service;
9. Charge for each service.

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

Note on Hospital Charges - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Member is responsible for balances. When you are unsure, ask the Hospital or the Claims Administrator for guidance.

Remember – Admission certification is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and within one business day after an emergency admission.

Failure to call the Managed Care Vendor may reduce your benefits (refer to *Section 5 – Cost Containment Features*).

Call the Managed Care Vendor (InforMed) at: (866) 475-1256

When Claims Should Be Filed – All claims must be received within 12 months of the date that the expenses were incurred. Claims received later than that date may be declined or subject to reduced reimbursement unless it is not reasonably possible to submit the claim in that time. After claims are received, each claim will be granted or denied by the Claims Administrator within the number of days specified in this section of the booklet for the specific type of claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan reserves the right to require that a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim; and
4. An explanation of why such material or information is necessary and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIMS AND APPEALS PROCESS

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Plan. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Plan shall review the claim itself or appoint an individual or an entity to review the claim.

A Claimant is not required to follow more than the claims and appeals process described below prior to bringing a civil action under ERISA or under state law, as applicable. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA.

If the Plan fails to adhere to the internal claims and appeals process required by this section , a Claimant shall be deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Section V of this section and is entitled to pursue any available remedies under ERISA section 502(a) or under state law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

The internal claims and appeals process will not be deemed exhausted based on minor violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception in the preceding paragraph, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any

such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Continued coverage for concurrent care shall be provided pending the outcome of an appeal.

Pre-Service Claims

In the case of a pre-service claim, including all pre-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care services in question.

In the case of a failure by a Claimant to follow the Plan's procedures for filing a pre-service claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. The above shall apply only in the case of a failure that:

(a) Is a communication by a Claimant that is received by the person or organizational unit designated by the Plan that handles benefit matters; and

(b) Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Post-Service Claims

In the case of a post-service claim, including all post-service claims that are not urgent care claims or concurrent care claims, the Plan shall notify the Claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above.

Calculation of Time Periods

For purposes of the time periods specified in this Section I, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notification of Adverse Benefit Determination

The Plan shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable, following an appeal of an Adverse Benefit Determination;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the Claimant not later than three (3) days after the oral notification.

II. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

The Plan provides three levels of internal appeals. The first two levels of internal appeals are administered by the Claims Administrator. The third level of internal appeals is administered by AMHIC. If a Claimant has exhausted the first two levels, the Claimant may submit a third appeal request to the Claims Administrator, which will forward the appeal to AMHIC for review. The third level of internal appeals is voluntary, which means the Claimant may file a request for an external review following the second level of internal appeals.

A Claimant has the right to file an appeal to the Plan within 180 days from the date of the initial Adverse Benefit Determination notice and within 30 days of the date of a second and third Adverse Benefit Determination notice. Appeal requests may be mailed to the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

The Claimant's appeal request must include the patient's name, identification number, and any additional documentation to be reviewed.

(a) A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(b) A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. For purposes of this section , such information will be considered "relevant" if it:

(i) Was relied on in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination;

(iii) Demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or

(iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(c) The Plan shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The Plan shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically:

(i) The Plan shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan issues a Final Internal Adverse Benefit Determination based on a new or additional rationale., The Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided, to give the Claimant a reasonable opportunity to respond prior to that date;

(e) The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits;

(f) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(g) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

(h) The Plan shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant. Requests may be faxed to the following number:

(410) 505-2677 or (866) 281-8554

All necessary information, including the Plan's appeal determination, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

III. DEADLINE FOR REVIEW DECISIONS

Urgent Care Claims

This Plan has three levels of internal appeals. In the case of Urgent Care Claims, the Plan shall notify the Claimant of the Plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

Pre-Service Claims

This Plan has three levels of internal appeals. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable time appropriate to the medical circumstances but not later than 15 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Post-Service Claims

This Plan has three levels of internal appeals. In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's appeal determination, with respect to any one of such three appeals, within a reasonable period but not later than 30 days after receipt of the Claimant's request for review of the Adverse Benefit Determination.

Calculation of Time Periods

For purposes of the time periods specified in this Section III, the period of time within which an appeal determination shall be made begins at the time an appeal is filed in accordance with the Plan procedures, without regard to whether all the information necessary to make an appeal determination accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary to decide the appeal, the period for making the appeal determination shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Notice of Appeal Determinations

The Plan shall provide the Claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant:

(a) The specific reason(s) for the adverse determination;

(b) A reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring a civil action under ERISA section 502(a) or under state law, as applicable;

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

(f) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) A statement that the Claimant may have other voluntary alternative dispute resolution options, such as mediation.

IV. GENERAL NOTICE REQUIREMENTS

When the Plan issues an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination, the notification shall meet the following requirements:

(a) The Plan shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings.

(b) The Plan shall provide to a Claimant, as soon as practicable, upon request, the diagnosis and treatment codes and their corresponding meanings, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review.

(c) The Plan shall ensure that the reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

(d) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(e) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman

established under PHSA section 2793 to assist individuals with internal claims and appeals and external review processes.

V. EXTERNAL REVIEW PROCESS

Request for External Review

The Plan shall allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The external review process applies only to an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves:

(a) Medical judgment, which includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is Experimental or Investigational, as determined by the external reviewer; and

(b) A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

Preliminary review

Within five (5) business days after receiving a Claimant's external review request, the Plan shall complete a preliminary review of the request to determine whether:

(a) The Claimant is (or was) covered under the Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Claimant was covered under the Plan when the health care item or service was provided;

(b) The health care service that is the subject of the Adverse Benefit Determination is a covered service under the Plan, but for a determination by the Plan that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The Claimant has exhausted the Plan's internal claims and appeals process, unless the Claimant is not required to do so, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim; and

(d) The Claimant has provided all the information and forms required to process the external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons for its ineligibility, as well as contact information for the Employee Benefits Security Administration (866-444-EBSA (3272)). If the request is incomplete, the notice shall describe the information or materials needed to complete the request, which must be received by the Plan within the four-month filing period or within 48 hours after receipt of the notice, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and incorporate an independent unbiased method for IRO selection. The IRO shall not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The agreement between the Plan and the assigned IRO shall include the following:

(a) The IRO shall utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The IRO shall provide the Claimant with written notice of the request's eligibility and acceptance for external review. The notice must inform a Claimant that he or she may submit additional information in writing to the IRO within 10 business days following receipt of the notice and that the IRO must consider such additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 business days, but it is not required to do so.

(c) Within five (5) business days after the date the IRO is assigned, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. The Plan's failure to timely provide such documents and information shall not delay the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the Adverse Benefit Determination. If the IRO does so, it shall notify the Claimant and the Plan within one (1) business day after making the decision.

(d) Upon receipt of any information submitted by the Claimant, the IRO shall forward the information to the Plan within one (1) business day. The Plan may then reconsider its Adverse Benefit Determination, but such reconsideration shall not delay the external review. If the Plan decides, on reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Claimant and IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

(e) The IRO shall review all of the information and documents timely received. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

(f) In addition to documents and information provided by the Claimant, the IRO shall consider the following items in reaching a decision (to the extent the information or documents are available and the IRO considers them appropriate):

(i) The Claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

(iv) The terms of the Claimant's Plan, to ensure that the IRO's decision is not inconsistent with the Plan's terms, unless the terms are contrary to applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and

(vii) The opinion of the IRO's clinical reviewer(s).

(g) Within 45 days after receiving the external review request, the IRO shall provide written notice of the final external review decision to both the Claimant and the Plan. The IRO's notice shall contain:

(i) A general description of the reason for the external review request, including information sufficient to identify the claim: date(s) of service, health care provider, claim amount (if applicable), diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial;

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(iv) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that the IRO relied on;

(v) A statement that the IRO's determination is binding on the Plan and the Claimant, unless other remedies are available under state or federal law;

(vi) A statement that judicial review may be available to the Claimant; and

(vii) Current contact information and phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

(h) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(i) An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law. The Plan shall provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Request for Expedited External Review

The Plan shall permit a Claimant to request an expedited external review when the Claimant receives:

(a) An Adverse Benefit Determination involving a Claimant's medical condition where the timeframe for completing an expedited *internal* appeal would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, and the Claimant has filed an expedited internal appeal request; or

(b) A Final Internal Adverse Benefit Determination involving (1) a Claimant's medical condition where the timeframe for completing a standard *external* review would seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not been discharged from a facility.

Immediately upon receiving the expedited external review request, the Plan shall complete a preliminary review to assess whether the request meets the reviewability requirements applicable under the standard external review process set forth above. The Plan shall immediately send the Claimant a notice regarding the Plan's reviewability assessment; this notice must meet the requirements applicable under the standard external review process set forth above.

Following a preliminary review determination that a request is eligible for external review, the Plan shall assign an IRO based on the standard external review process set forth above. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO.

The documents and information can be provided electronically, by telephone or facsimile, or any other expeditious method available.

The IRO shall consider the documents and information according to the procedures for standard external review set forth above, to the extent the documents or information are available and the IRO considers them appropriate. In reaching a decision, the IRO shall review the claim anew and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The agreement between the Plan and the IRO shall require the IRO to provide notice of its final external review decision; this notice must meet the requirements applicable under the standard external review process set forth above. The notice must be provided as expeditiously as the Claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours after the date it provides the non-written notice.

VI. DEFINITIONS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on a determination of a Claimant's eligibility to participate in the Plan. An Adverse Benefit Determination includes determinations based on utilization review, Experimental or Investigational exclusions, and Medical Necessity, in addition to any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time. A rescission means a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required contributions toward the cost of coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Urgent Care Claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim for purposes of this claims and appeals process.

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

1. Occupational disease laws.
2. Employer's liability laws.
3. Municipal, state, or federal law.
4. Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Compensation Order Review Board.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury **even if other benefits are not Paid because:**

1. You fail to file a claim within the filing period allowed by the applicable law.
2. You obtain care which is not authorized by Workers' Compensation insurance.
3. Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
4. You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile no-fault insurance policy. A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or no-fault statute.

How We Coordinate Benefits With Complying Policies

Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.

After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the no-fault statute. If there is more than one complying policy, each will have to pay its maximum no-fault statutory coverages before we will become liable for any further Payments.

If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.

The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the no-fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens If You Do Not Have a Complying Policy

The Plan will not pay benefits for Injuries received by the Participant, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile no-fault complying policy as required by law. Benefits will be provided under the terms of the Plan for Injuries sustained by a Participant who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Participant is not covered by a complying policy. In that event, we may exercise our rights under *Section 12 - Third-Party Liability — Subrogation.*

SECTION 12

SUBROGATION, REIMBURSEMENT, AND RECOVERY

The Plan's and the Participant's duties and responsibilities with respect to rights of subrogation, reimbursement, and recovery are described in this Section. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA, and therefore, certain rights, duties and responsibilities may be modifiable or inapplicable depending upon whether ERISA or state law is applicable to a plan.

Conditional Payment of Benefits

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits ("Conditional Payment") (1) to any one or more of the following: (a) a Participant; (b) a Participant's Dependents, beneficiaries, estate, personal representative, heirs, and/or assigns, and a guardian of a minor or incapacitated Participant (each individually referred to hereinafter as a "Related Party" and collectively as "Related Parties"); (2) in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from, the acts or omissions of a Participant, his or her Dependents, or a third party; (3) where any party besides the Plan may be responsible for expenses arising from such injury, sickness, disease, or disability; and/or (4) compensation for such expenses is available through another source, including but not limited to the following (collectively referred to hereinafter in this Subrogation, Reimbursement, and Recovery Section as "Other Coverage"):

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Any worker's compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, medical, disability or other benefit payments, or school insurance coverage;
    f. Any judgment at law or other settlements; and/or
    g. Any other recovery to which a Participant or Related Party is entitled, for or in relation to a facility-acquired condition, Provider error, or damages arising from another party's act or omission for which the Plan has not already been refunded.

2. The Participant agrees that acceptance of the Plan's Conditional Payment is constructive notice of these provisions in their entirety. The Plan shall have a right to the imposition of a constructive trust on 100 percent of the Plan's Conditional Payment or the full extent of payment from Other Coverage, and the Participant or Related Party shall not disburse or dissipate such payment except for reimbursement to the Plan or the Plan's assignee.

3. In the event a Participant or Related Party submits or files a claim for reimbursement through any Other Coverage, such Participant or Related Party must send Written Notice within 30 days after submitting or filing such claim to the Plan at the following address:

AMHIC
c/o CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998
(877) 889-2478

4. If the Related Party asserts a claim against a third party based on the Participant's injury, sickness, disease, or disability, the Related Party and any settlement or judgment recovered by the Related Party shall be subject to the Plan's liens and other rights to the same extent as if the Participant had asserted the claim. The Plan may assign its rights to enforce its liens and other rights.

5. If more than one party is or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, an unallocated settlement fund, intended to compensate multiple injured parties of which the Participant or Related Parties are such parties, is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

6. As a condition to the Participant's receipt of benefits under this Plan, the Participant agrees the Plan shall have an equitable lien on any funds received by the Participant, and/or his or her attorney or Related Party from any source or through Other Coverage, the Plan shall have a right to the imposition of a constructive trust on such funds, and the Participant shall segregate and not disburse or dissipate such funds until such time as the obligations under this provision are fully satisfied. The Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. In the event a Participant or Related Party settles with or recovers from a third party, or is reimbursed by any Other Coverage, the Plan shall be reimbursed by the Participant or Related Party out of such judgment, settlement, or reimbursement received for all benefits paid or that will be paid by the Plan on behalf of the Participant or to the Related Party. If the Participant or Related Party fails to reimburse the Plan out of any judgment or settlement received, the Participant or Related Party will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to the Participant's receipt of benefits under this Plan, the Plan reserves the right to be subrogated to and to pursue any and all claims, causes of action or rights with respect to benefits under this Plan that may arise against any person, corporation and/or entity and to any Other Coverage to which a Participant or Related Party is entitled, regardless of how classified or characterized, at the Plan's sole discretion. The Plan will be subrogated as of the time it mails or delivers a written notice of its exercise of this option to the Participant, his or her attorney, or a Related Party.

2. As a condition to the Participant's receipt of benefits under this Plan, an automatic equitable lien attaches in favor of the Plan upon any claim which a Participant or Related Party may have against any Other Coverage and/or party causing the injury, sickness, disease, or disability to the extent of the value of the Conditional Payment plus reasonable costs of collection.

3. In its sole discretion, the Plan, in its own name or in the name of a Participant or Related Party, may commence a proceeding or pursue a claim against any party or source of Other Coverage for the recovery of all damages to the full extent of the value of any such benefits or Conditional Payment advanced by the Plan.

4. If a Participant fails to file a claim or pursue damages against any party or source of Other Coverage, (1) the Plan is authorized to pursue, sue, compromise and/or settle any such claims in the Participant's and/or the Plan's name, (2) the Plan shall require the Participant

or Related Party to cooperate fully with the Plan in the prosecution of any such claims, and (3) the Participant or Related Party is deemed to assign all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources of Other Coverage.

Right of Reimbursement

1. The Plan shall be entitled to recover 100 percent of the benefits paid, without deduction for court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, or application of the common fund doctrine, made whole doctrine, or any other similar legal theory and without regard to whether a Participant or Related Party is fully compensated by his, her, or its recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's rights of subrogation, reimbursement, and recovery may not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, may not be applicable to the Plan and may not reduce the Plan's rights.

4. These rights of subrogation, reimbursement, and recovery shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by a Participant.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation, reimbursement, and recovery shall apply without regard to the location of the event that led to or caused the injury, sickness, disease, or disability.

Excess Insurance – If at the time of injury, sickness, disease, or disability experienced by a Participant, any Other Coverage is available to such Participant, benefits under this Plan shall apply only as an excess over such sources of Other Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

Separation of Funds – Benefits paid by the Plan, funds recovered by a Participant or Related Parties, and funds held in a constructive trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant, such that the death of the Participant, or filing of bankruptcy by the Participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's rights to subrogation, reimbursement, and recovery.

Wrongful Death – In the event that a Participant dies as a result of injury, sickness, disease, or disability and a wrongful death or survivor claim is asserted against a third party or any Other

Coverage, the Plan's subrogation, reimbursement, and recovery rights shall still apply, and the Related Party pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid to or on behalf of a Participant, Related Parties and all others that benefit from such payment.

Participant's Obligations

1. It is a Participant's obligation at all times, both prior to and after payment of benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including participating in discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information (1) regarding the Participant's injury, sickness, disease, or disability, including accident reports, settlement information and any other requested additional information, and (2) related to the filing of an action or submission of a claim, including all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Participant's attorney, the third party, and the parties administering Other Coverage to pay the Plan directly;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its rights of subrogation, reimbursement, and recovery;
    d. To do nothing to prejudice the Plan's rights of subrogation, reimbursement, and recovery;
    e. To reimburse the Plan promptly when a recovery through settlement, judgment, award or other payment has been received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant or Related Parties may have such a claim against any responsible party or with respect to Other Coverage. If a Participant, his or her attorney, or Related Party fails to reimburse the Plan for all benefits paid or to be paid, with respect to an injury, sickness, disease, or disability, out of any proceeds, judgment or settlement received, the Participant or Related Party will be responsible for any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with the Plan's attempt to recover the value of such benefits from the Participant or Related Parties.

2. The Plan's rights of subrogation, reimbursement, and recovery are in no way dependent upon a Participant's cooperation with or adherence to these terms.

Rights of Recovery – In accordance with the Recovery of Payments section, whenever payments have been made by this Plan to a Participant or Related Parties in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan to a Participant, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan, in its sole discretion, may determine: the Participant or Related Parties; a Participant's legal representative; any insurance company; any other individual or entity which the Plan determines is responsible for payment of such amount; and/or any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments – Occasionally, benefits are paid (1) more than once, (2) based upon improper billing or a misstatement in claim or enrollment information, (3) not according to the Plan's terms, conditions, limitations or exclusions, (4) based upon a fraudulent claim or a claim that is the result of a Provider's misstatement, or (5) for reasons that otherwise should not have been allowed by the Plan. In this case, the Plan reserves the right to pursue reimbursement of and/or recover Payments Made in Error from a Provider, another benefit plan, insurer, or any

other person or entity to whom an assignment of benefits has been made by a Participant or Related Party, and/or the Participant or Dependent on whose behalf such payment was made, and to require such party to return or refund the Payments Made in Error to the Plan within 30 days of discovery or demand. If the Plan must bring an action against such party to recover such payments, then the Plan reserves the right to seek any and all court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses associated with such litigation from such party, regardless of the action's outcome. Furthermore, if the Plan seeks recovery of such payments, a Provider or other party shall be required to abstain from billing the Participant or Related Party for any outstanding amount in connection with the Payments Made in Error. The Claims Administrator shall have no obligation to secure payment for the expense for which the Payments Made in Error was made or to which it was applied. The Claims Administrator shall have the sole discretion to choose the person or entity from which it will seek recovery of the Payments Made in Error and whether it shall require that such recovery be made in a lump sum.

Deduction and Offset of Payments – The failure by a Participant, his or her attorney or Related Parties to comply with any of the requirements of subrogation, reimbursement, and recovery under this Section may, in the Plan's sole discretion, result in a forfeiture of payment by the Plan of benefits due under existing or new claims, including future benefits under any other group benefits plan maintained by the Employer for any other injury, sickness, disease, or disability experienced by a Participant. Any funds or payments due under this Plan on behalf of the Participant may be withheld until the Participant or Related Party satisfies his, her or its obligations with respect to subrogation, reimbursement, and recovery. In addition, the Plan, in its sole discretion, may deduct from and/or offset any benefits properly payable to a Participant or Related Parties the amount of any one or more of the following payments:

1. Payments Made in Error;
2. A payment pursuant to a misstatement in a claim, a fraudulent claim or other fraudulent act;
3. A payment pursuant to a misstatement made in order to obtain coverage under this Plan when such payment is made within two years of the date that such coverage commenced. No such misstatement shall be used to reduce benefits under this Plan after coverage has been in force for a period of two years unless (1) such statement is contained in a written instrument signed by the Participant making such statement, and (2) a copy of that instrument is or has been furnished to the Participant or Related Parties;
4. A payment with respect to a person ineligible for coverage under the Plan;
5. A payment made in anticipation of obtaining a recovery if a Participant or Related Party fails to comply with the subrogation, recovery, and reimbursement provisions; or
6. A payment pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

A deduction from or offset of any payments due to a Participant or Related Party may be subject to a Participant's rights, if any, with respect to benefits under the Claims and Appeals process.

Participant Under a Disability (Including Minors) – In the event a Participant is under a disability, including a minor as that term is defined by applicable law, the Plan shall require that the Participant's parents or court-appointed guardian cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the Participant and his or her estate, insofar as these subrogation, reimbursement, and recovery provisions are concerned. Any

court costs or legal fees associated with obtaining such approval shall be paid by the Participant's parents or court-appointed guardian.

Language Interpretation – AMHIC and anyone acting on its behalf retains sole, full and final discretionary authority to construe and interpret the language of this Section, to determine all questions of fact and law arising under this Section, and to administer the Plan's subrogation, reimbursement, and recovery rights. Except as expressly provided herein, this Section does not address a Provider's rights and obligations under AMHIC's contracts with health care Provider networks to provide services to our Members.

To the extent that any portion of this Section of the Plan is inconsistent with applicable law, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the Plan shall remain in full force and effect.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage – If you have duplicate (double) coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage, the total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered expenses.

Definition – For this section, the following terms are used:

1. **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. A "plan" also includes coverage provided by exclusive or preferred provider organizations, but excludes school accident-type coverage.
   b. Coverage under labor management trusteed plans, union welfare plans, and employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

   We consider each policy, contract, or other arrangement for benefits a separate plan. That part of any such contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate plan.
2. **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
3. **Secondary Plan** refers to the plan (or plans) which have second responsibility (liability) for a claim.

Conditions of Coordination of Benefits – The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits – You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the primary plan.

How We Determine Which Plan Is Primary and Which Is Secondary – We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

1. A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
2. A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a dependent under that coverage.
3. If both plans cover the Member as a dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and dependent(s) longest is primary over the plan which has covered the **other parent** and dependent(s) for a shorter period of time.
4. When the parents are separated or divorced, and the parent with custody of the Child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
5. When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
6. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent).
7. When the above rules do not establish the order of benefit determination, the plan which has covered the Participant for the longest period of time is primary.

Right to Receive and Release Necessary Information – We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment – When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery – If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers – You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees, Spouses and Domestic Partners Age 65 and Over - When an Active Employee age 65 or over and the covered Spouse or Domestic Partner of any such Employee age 65 or over become eligible for Medicare, the individual must choose either of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees, Spouses or Domestic Partners Age 65 and Over – Please refer to *Section 4 - Membership Eligibility* for eligibility requirements. AMHIC-eligible retirees and their Spouses and Domestic Partners who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the Plan will be secondary for the Participant if the individual is age 65 and over and retired. Medicare is primary and the Plan will be secondary for the Spouse or Domestic Partner if both the Member and their covered Spouse or Domestic Partner are 65 and retired.

If the Medicare-eligible retiree (or Spouse or Domestic Partner) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the Plan will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the three-month waiting period or a maximum of 33 months, when applicable. After the initial 30 months or 33 months, as the case may be, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare – Medicare is the primary payer for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member, then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare Due to ESRD at the Time of COBRA Election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare Due to Age at the Time of COBRA Election – Medicare is the primary payer and the COBRA plan is the secondary payer. However, when a member is covered under the group health plan by virtue of the current employment status of the individual or a Spouse or Domestic Partner of any age, then Medicare is the secondary payer.

Medicare Due to Disability at the Time of COBRA Election - Medicare is the primary payer for individuals entitled to Medicare due to disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the current employment status of the individual or a family member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

AMHIC agrees to the following:

1. AMHIC will not disclose PHI to the Employer, unless it receives a certification by the Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed to AMHIC and CareFirst Administrators, as necessary, in order to allow AMHIC and CareFirst Administrators to carry out administrative functions on behalf of the Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure. The following disclosures are NOT permitted without the individual's authorization:

    a. Disclosures by a health care provider that provides services to a Member under the Plan, if the disclosures do not comply with the provisions of the plan documents;
    b. Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.

3. AMHIC agrees it will not use or further disclose PHI other than as permitted or required by the plan documents or as required by law.
4. AMHIC agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law.
5. AMHIC agrees to report to the Employer any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
6. AMHIC agrees to permit individuals to have access to any PHI, which it has received on behalf of the Plan, in accordance with AMHIC's Release of Patient Information – Patient Access Policy.
7. AMHIC agrees to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
8. AMHIC agrees to make available the information required to provide an accounting of disclosures in accordance with AMHIC's HIPAA Privacy of Health Information Policy and Procedure.
9. AMHIC agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received on behalf of the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with Federal privacy regulations regarding PHI.
10. AMHIC agrees, if feasible, to return or destroy all PHI received on behalf of the Plan that is maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, AMHIC agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
11. In order to provide adequate separation between the Plan and the Employer, those employees or agent of AMHIC described below may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care

Operations, or other matters pertaining to the Plan in the ordinary course of business is included in this description.

a. Those who are assigned to the administration of the Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Plan.
b. Others who are authorized to have access to PHI on behalf of AMHIC, for purposes permitted by the plan documents.

12. AMHIC agrees to restrict the access to and use of PHI received on behalf of the Plan by staff (as described in item 11 above) to the administrative functions that AMHIC or CareFirst Administrators performs on behalf of the Plan.
13. AMHIC agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any employee or agent of AMHIC, including a subcontractor, who is authorized to have access to a Member's PHI violates any of the provisions of the plan documents as set forth in this policy. Such process will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

AMHIC Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by AMHIC on behalf of the Plan, AMHIC shall reasonably safeguard the Electronic Protected Health Information as follows:

1. AMHIC shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that AMHIC creates, receives, maintains, or transmits on behalf of the Plan;
2. AMHIC shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. AMHIC shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. AMHIC shall report to a Member's Employer any Security Incidents of which it becomes aware as described below:

    a. AMHIC shall report to the Employer within a reasonable time after AMHIC becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and
    b. AMHIC shall report to the Employer any other Security Incident on an aggregate basis every quarter or more frequently upon such Employer's request.

SECTION 16

OUT-OF-AREA SERVICES

CareFirst Administrators has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Participants access health care services outside the geographic area CareFirst Administrators serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst Administrators for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Participants under this agreement are described generally below.

Typically, Participants, when accessing care outside the geographic area CareFirst Administrators serves, obtain care from health care providers that have a contractual agreement (i.e., are “participating health care providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Participants may obtain care from non-participating health care providers. CareFirst Administrators’ payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Participants access covered health care services within the geographic area served by a Host Blue, CareFirst Administrators will remain responsible to AMHIC for fulfilling CareFirst Administrators’ contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, CareFirst Administrators’ action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Participant’s liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to CareFirst Administrators by the Host Blue.

The calculation of AMHIC’s liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to CareFirst Administrators by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to CareFirst Administrators by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases,

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant and AMHIC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst Administrators is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that AMHIC pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from AMHIC. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining Participant liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst Administrators would then calculate Participant liability and AMHIC's liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, CareFirst Administrators may request adjustments from the Host Blue for full refunds from health care providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process

for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or health care provider contracts or would jeopardize its relationship with its health care providers.

BlueCard Program Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

Some of these fees and compensation are charged each time a claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency fees, and ITS transaction fees. An access fee may be passed on to AMHIC as an additional claim liability or as a separate amount. If one is charged, it will be a percentage of the discount/differential CareFirst Administrators receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. An administrative expense allowance fee (AEA) may be passed on to AMHIC. If one is charged it will be a fixed amount per claim. Other Program-related fees that CareFirst Administrators may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO health care provider directories. All BlueCard Program-related program fees, including any access fees paid to Host Blues, are stated in CareFirst Administrators' contractual agreement with AMHIC.

How the BlueCard Program Access Fee Affects AMHIC

When CareFirst Administrators is charged a BlueCard Program access fee, CareFirst Administrators may pass the charge along to AMHIC as a claim expense or as a separate amount. The access fee will not exceed $2,000 for any claim. If CareFirst Administrators receives an access fee credit, CareFirst Administrators will give AMHIC a claim expense credit or a separate credit.

Instances may occur in which the claim payment is zero or CareFirst Administrators pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, CareFirst Administrators will pay the Host Blue's access fee and pass it along to AMHIC as stated above even though AMHIC paid little or had no claim liability.

Non-Participating Health Care Providers Outside CareFirst Administrators' Service Area

Participant Liability Calculation

1. In General

   When covered health care services are provided outside of CareFirst Administrators' service area by non-participating health care providers, the amount(s) a Participant pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst Administrators may pay claims from non-participating health care providers outside of CareFirst Administrators' service area based on the provider's billed charge, such as in situations where a Participant did not have reasonable access to a participating health care provider, as determined by CareFirst Administrators in CareFirst Administrators' sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst Administrators may pay such claims based on the payment CareFirst Administrators would make if CareFirst Administrators were paying a non-participating health care provider inside of CareFirst Administrators' service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than CareFirst Administrators' in-service area non-participating health care provider payment, or in CareFirst Administrators' sole and absolute discretion, CareFirst Administrators may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment CareFirst Administrators will make for the covered services as set forth in this paragraph.

Fees and Compensation

AMHIC understands and agrees to reimburse CareFirst Administrators for certain fees and compensation which CareFirst Administrators is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by AMHIC. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with AMHIC's benefit period under this agreement.

In addition, CareFirst Administrators must pay an administrative fee to the Host Blue, and AMHIC further agrees to reimburse CareFirst Administrators for any such administrative fee. The negotiated fees are stated in CareFirst Administrators' contractual agreement with AMHIC.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

CERTIFICATE OF COVERAGE

IN WITNESS WHEREOF, the Association Mutual Health Insurance Company has caused this Qualified High Deductible Health Plan Certificate of Coverage, effective January 1, 2013, to be executed by its duly authorized representative.

By: Rhona N Byer

Name: Rhona N Byer

Title: Executive Director

Date: 11/7/2013