National Health Insurance Company

[59 Maiden Lane, Suite 610, New York, New York 10038][1]

[1-800-847-8361][2]

EMPLOYER GROUP INSURANCE
CERTIFICATE OF GROUP INSURANCE

This individual Certificate is issued as evidence of the insurance provided under the Group Policy (the Policy), issued to the above Policyholder.

The insurance described herein is effective only if the individual is eligible for such insurance, premiums are paid to the Insurance Company on account of such individual and the individual becomes and remains insured as provided in the Policy. The provisions described in this Certificate are subject to all the provisions, terms and conditions of the Policy. The Policy may be amended, changed, canceled or discontinued in accordance with the provisions thereof, without the consent of the individual. This Certificate supersedes and replaces any and all other insurance certificates and riders that may have been issued to the individual insured under any and all Group Policies issued to the Policyholder by:

[30-DAY RIGHT TO RETURN THE CERTIFICATE

If for any reason You are not satisfied with this Certificate, You may return it to Us within 30-days after You receive it. We will refund any premium paid and Your coverage issued under the Policy will be deemed void, just as though coverage had not been issued.] [3]

NATIONAL HEALTH INSURANCE COMPANY

(Herein referred to as the Insurance Company, We, Our or Us)

[ ][ ][4]

SECRETARY **PRESIDENT**

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In-Network benefit level shown in the Schedule of Benefits, until the Insured Person is Stabilized and can be safely transported to an In-Network Provider as determined the attending Physician.

Insured Persons who have complaints regarding their ability to access needed medical care in a timely manner may complain to Us and to the California Department of Insurance. Our address and customer service telephone number are: **National Health Insurance Company, c/o Meritain Health, [1405 Xenium Lane North Ste 140; Minneapolis, MN 55441 1-800-847-8361**.][5] **The address and toll free telephone number of the Consumer Services Division of the Department of Insurance is: 300 South Spring Street; Los Angeles, CA 90013 1-800-927-HELP, TDD: 800-482-4TDD. The web address is (www.insurance.ca.gov).**

You must meet higher deductibles and higher out-of-pocket maximums for Out-Of-Network Provider services than for In-Network Provider services.

If medically appropriate care cannot be provided In-Network, We will arrange for the required care with the available and accessible providers Out-Of-Network. You will be responsible for paying the In-Network cost sharing for the service. In addition to In-Network Copayments and Coinsurance, In-Network Cost Sharing includes applicability of the In-Network Deductible and accrual of Cost Sharing to the In-Network Out-of-Pocket Maximum.

Except as provided herein and on the Schedule of Benefits, We will not begin to pay for Your health care expenses until after Your health care bills exceed the Deductible amount and You will have to pay for all of Your health care bills until these bills exceed Your Deductible amount.

The provisions and benefits described herein may be different from any and all group insurance coverage You may have or have had. Please read this Certificate carefully.

CERTIFICATE FACE PAGE

Certificate Issued To: [Insured_Name][6]»

Herein Called the Employee and to Insured Dependents:

[Dependent_1»][7]	«Dependent_2»]
[Dependent_3»]	«Dependent_4»]
[Dependent_5»]	«Dependent_6»]
[Dependent_7»]	«Dependent_8»]
[Dependent_9»]	«Dependent_10»]
[Dependent_11»]	«Dependent_12»]

Effective Date of Insured: [Insured_Effective_Date»][8]

Policy Number: [Policy»][9]

Policyholder, Employer and Plan Administrator: [The ABC Company»][10]

Employer Effective Date: [Employer_Effective_Date»][11]

COVERAGE ISSUED: [Coverages»][12]

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PART 1 – DEFINITIONS

ACCIDENT/ACCIDENTAL means any sudden or unforeseen event which:

1. Results from an external agent or trauma;
2. Is definite as to time and place; and
3. Happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

ACUPUNCTURE means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body to assist in rehabilitation and restoration of previously existing normal bodily functions but only if provided by a Physician or licensed acupuncturist.

AGGREGATE FAMILY DEDUCTIBLE AND AGGREGATE FAMILY OUT-OF-POCKET MAXIMUM In a traditional family plan, an individual is responsible only for the single Out-of-Pocket Deductible and a single Out-of-Pocket Maximum amount. Deductibles and other Cost Sharing payments made by each individual in a family contribute to the family Deductible and Out-of-Pocket Maximum. Once the family deductible amounts is satisfied by any combination of individual Deductible payments, then plan Copays and/or Coinsurance apply until the family Out-of-Pocket Maximum is reached, after which We pay for Covered Charges for all family members. Under high deductible health plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family Out-of-Pocket Maximum must be satisfied before any individuals cost sharing responsibility ends.

AMBULANCE means:

1. A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care or from covered services;
2. A non-emergency licensed ambulance or psychiatric van service when the vehicle transports an Insured Person from or to covered services and the use of other means of transportation may endanger the Insured Person's health; and
3. Air ambulance charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the condition instead of local Ambulance service.

AMBULATORY SURGICAL CENTER means any public or private establishment: a) with an organized medical staff of Physicians; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Physician services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

CERTIFICATE/CERTIFICATE OF INSURANCE means the summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

CHEMICAL DEPENDENCY means the abuse of or psychological or physical dependency on or addiction to a controlled substance.

COINSURANCE/COINSURANCE PERCENTAGE means the Insured Person's share of Covered Charges under the Policy after any applicable Copays and Deductibles are satisfied and before the Out-of-Pocket Maximum is reached. The Coinsurance Percentage is shown in the Schedule of Benefits.

COPAY means the amount required to be paid by an Insured Person each time a specific service is provided, as set forth in the Schedule of Benefits. Services requiring Copays and Copay amounts are shown in the Schedule of Benefits.

COSMETIC SURGERY means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or self-esteem.

COST-SHARING means the amounts an Insured Person must pay for Covered Charges, expressed as Coinsurance, Copayments, and/or Deductibles.

COVERED CHARGES means charges incurred by or on behalf of an Insured Person while the Policy is in force with respect to such Insured Person and which:

1. Are Medically Necessary and which have been recommended and prescribed by a Physician;
2. Are not in excess of Reasonable and Customary Charges; and
3. Are not excluded from coverage by the terms of the Policy.

CUSTODIAL OR CONVALESCENCE CARE means any care that is provided to an Insured Person who is disabled and needs help to support the essential activities of daily living when the Insured Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

DEDUCTIBLE means the amount of applicable Covered Charges other than Copays, that must be incurred by an Insured Person in any Year before benefits will be payable under the Policy. A higher Deductible amount may apply when Out-of-Network Providers are utilized for non-Emergency care except as provided herein and on the Schedule of Benefits. The Deductible is shown in the Schedule of Benefits.

DEPENDENT/ELIGIBLE DEPENDENT means an Employee's:

1. Spouse, who is not legally separated or divorced from the Employee and is not a member of the armed forces.
2. Child for whom the Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by the Employee and who has not reached the age of 26;
3. Domestic Partner;
4. Domestic Partner's child who is covered on the same basis as an Employee's stepchild;
5. Disabled child over the age of 26. Such child is eligible to continue coverage under the Policy and to be initially enrolled under the Policy

A Dependent spouse or Dependent Domestic Partner who also is an eligible Employee may be insured as either an Employee or Dependent but not as both.

DOMESTIC PARTNER means an adult who has chosen to share their life with an Employee in an intimate and committed relationship of mutual caring. The domestic partnership must be established in California by the filing of a Declaration of Domestic Partnership with the Secretary of State.

DURABLE MEDICAL EQUIPMENT means equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose;
3. Prescribed by a Physician and Medically Necessary; and
4. Appropriate for use in the home.

ELIGIBLE EMPLOYEE means an Employee who works the required number of hours as defined by the master application. The term does not include an Employee who:

1. Works on a part-time, basis;
2. Is covered under:
   a. Another Health Benefit Plan; or
   b. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
3. Elects not to be covered under the Employer's health benefit plan; or
4. Is covered under:
   a. The Medicaid program;
   b. Another federal program, including the CHAMPUS program or Medicare program; or
   c. A benefit plan established in another country.

An Employee also is a Retiree, tribal member, officer, partner or director as designated by the Employer in the master application and approved by Us.

EMERGENCY ADMISSION means an admission of an Insured Person who experiences an Emergency Medical Condition.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Active labor.

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

Emergency Services also includes services rendered for a psychiatric emergency.

EMPLOYEE means an individual employed by an Employer.

EMPLOYER means a sole proprietorship, partnership or corporation who is actively pursuing business interests and has applied for the Policy in connection with its own employee welfare benefit plan. An Employer must complete an Employer Application agreeing to all the terms specified by Us and meet all other requirements in the state of the state of California. The Employer is deemed the Plan Administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act ("ERISA") and Consolidated Omnibus Budget Reconciliation Act ("COBRA").

EMPLOYER'S EFFECTIVE DATE means the Effective Date of coverage for Your Employer.

ENROLLMENT DATE means the date an Employee or Dependent enrolls under the Policy or, if earlier, the first day of any Service Waiting Period that must be satisfied before coverage becomes effective.

ENROLLMENT FORM means the form designated by Us that an Employee must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from Your Employer and must be submitted to Your Employer to be forwarded to Us.

ESSENTIAL HEALTH BENEFITS has the same meaning as found in section 1302(b) of the federal health care reform's Patient Protection and Affordable Care Act including any amendments, regulations, rules or other guidance issues with respect to the Act and in Section 10112.27 of the California Insurance Code.

EXPERIMENTAL OR INVESTIGATIONAL means a service for which one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 2. is true based on:
    a. Published reports in authoritative medical literature; and
    b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
    a. It does not have FDA approval; or
    b. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
        1) Included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        2) Included in a prescription drug reference compendium; or
        3) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.

4. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5 applies for protocols used by the Insured Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

GEOGRAPHIC AREA means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided, or a greater area if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply.

HABILITATIVE SERVICES means Medically Necessary health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH BENEFIT PLAN means any Hospital or medical policy or certificate, Hospital or medical service plan contract, or health maintenance organization subscriber contract.

HOME HEALTH CARE means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

HOSPICE means a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

HOSPICE SERVICE means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an Insured Person who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family of the hospice patient.

HOSPICE TEAM means a group of persons composed of a Hospice Physician, a patient care coordinator (a Physician or licensed graduate registered nurse (RN)), a licensed graduate registered nurse (RN), a mental health specialist, a social worker, a Chaplain and a lay volunteer.

HOSPITAL means a legally constituted and licensed institution with organized facilities for the care and treatment of sick and injured persons on an Inpatient basis. This includes facilities for diagnosis and surgery under the supervision of a staff of one or more Physicians that provides 24 hour nursing service by licensed graduate registered nurses (RNs) on duty or call. It does not mean Custodial, Convalescent, nursing, rest or Extended Care facilities.
For the purpose of Severe Mental Health Conditions, Hospital includes an acute psychiatric Hospital as defined in subdivision (b) of Section 1250 of the California Health and Safety Code, a psychiatric health facility as defined by Section 1250.2 of the California Health and Safety Code operating pursuant to licensure by the State Department of Mental Health and a facility licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250 of Division 2 of the California Health and Safety Code).

IMMEDIATE FAMILY means (step) brothers, (step) sisters, (step) children, (step) parents, aunts, uncles Domestic Partners, and legal spouses.

INITIAL ENROLLMENT PERIOD means the period of time during which an Employee or Dependent is first eligible to enroll under the Policy.

INJECTABLE AND SPECIALTY MEDICATION means those covered drugs that are intravenously, intramuscularly, or subcutaneously, or are used as immunosuppressant agents in organ transplant patients. Coverage for outpatient prescription drugs shall also include coverage for disposable devices that are medically necessary for the administration of a covered outpatient prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectible outpatient prescription drugs that are not dispensed in pre-filled syringes. For purposes of this section, the term "disposable" includes devices that may be used more than once before disposal.

IN-NETWORK means those Covered Charges received from a Preferred Provider.

INPATIENT means an Insured Person confined and assigned to a Hospital bed for a period of twenty-three (23) consecutive hours or longer upon the advice of a Physician for other than Custodial or Convalescent Care.

INSURED PERSON/INSURED means the Employee named in the Schedule of Benefits and any Covered Dependents whose coverage with Us is in effect and has not terminated.

INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an Intensive Care Unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards. This care includes close observation by trained and qualified personnel primarily assigned to this part of the Hospital. This term shall not include Intermediate Care or Stepdown Units.

LIFE-THREATENING means a condition which, if not immediately interrupted by medical treatment, has a high likelihood of: (1) death, if the end point of the medical treatment is survival; or (2) causing major irreversible morbidity (including: loss of arm, leg, hand or foot; loss of sight or hearing; paralysis; or loss of brain function), if the end point of the medical treatment is survival and/or avoiding that morbidity. The attending Physician must verify the condition to be life-threatening.

MEDICALLY NECESSARY means a Service that is medically appropriate and required to prevent, diagnose, or treat an Insured Person's condition or clinical symptoms in accordance with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII, Social Security Amendments of 1965, as amended.

MENTAL HEALTH CONDITIONS means mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Mental Health Conditions also include the following conditions:

1. Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.
2. A Serious Emotional Disturbance of a child under age 18. A Serious Emotional Disturbance of a child under age 18 means a condition identified as a mental disorder in the DSM, other than a primary Substance Use Disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
    a. As a result of the mental health condition, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental health condition and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
    b. The child displays psychotic features, or risk of suicide or violence due to a mental disorder; or
    c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

Refer to the Mental Health Conditions/Substance Use Disorders for the benefits.

NEGOTIATED RATE means the rate mutually agreed upon between Us and a Provider in a specific instance.

OCCUPATIONAL THERAPY means treatment of disease by physical agents and methods to assist in rehabilitation and restoration, of previously existing normal bodily functions which were lost or compromised, through a program designed to improve endurance, strength, exercise tolerance, and performance of activities of daily living (ADL), but only if such treatment results in measurable improvement and is provided by a Physician or licensed or registered occupational therapist (O.T.R.). Maintenance therapy or other treatment provided on a routine basis as part of a standard program, and educational training or services designed and adapted to develop a physical function, are not included.

OUT-OF-NETWORK PROVIDER means any Physician, Hospital or other health care Provider who is not a member of a PPO network contracted with Us to provide medical services to Our Insureds.

OUT-OF-POCKET MAXIMUM means the maximum amount of Covered Charges You will pay in a Year. The Out-of-Pocket Maximum includes applicable Copays and the Deductibles. The Out-of-Pocket Maximum is shown in the Schedule of Benefits. After the Out-of-Pocket Maximum is reached, We will pay the remainder of the Covered Charges incurred by an Insured Person during the rest of that Year.

The Cost-Sharing for Out-of-Network Emergency Services, including both emergency medical transportation and emergency Hospital care, accrue to the In-Network Out-of-Pocket Maximum.

A higher Out-of-Pocket Maximum, as shown in the Schedule, may apply when Out-of-Network Providers are utilized.

OUTPATIENT DAY PROGRAM means a time-limited, medically-monitored program that offers comprehensive, intensive, individually planned, coordinated, and structured services. A day program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist Insured Persons in achieving the goals identified in their individual treatment plans. Day programs are typically offered four or more days per week, with some available in the evenings and on weekends. Such a program functions as a step-down or alternative to Inpatient care or partial hospitalization, as transitional care following an Inpatient or partial hospitalization stay in order to facilitate return to the community or to prevent or minimize the need for a more intense or restrictive level of treatment. Day programs are more intensive than Outpatient treatment and serve persons who need a structured behavioral health setting for daytime activities.

OUTPATIENT HOSPITAL EXPENSES means Covered Charges incurred by an Insured Person that are not on an Inpatient basis.

OUTPATIENT PRESCRIPTION DRUGS are self-administered drugs approved by the Federal Food and Drug Administration for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an Inpatient basis.

For purposes of this section “inpatient basis” has the meaning indicated in Section 1300.67(b), and “self-administered” means those drugs that need not be administered in a clinical setting or by a licensed health care provider.

OVER-THE-COUNTER DRUGS AND PRODUCTS means a drug or product that can be dispensed without the following statement on the label: “Caution: Federal law prohibits dispensing without a prescription”.

PHYSICIAN means a person who has successfully completed the prescribed course of studies in medicine at an officially recognized medical school and has acquired the requisite qualifications for licensure in the practice of medicine. The person must be a legally qualified, licensed practitioner who provides care within the scope of his/her license, and who is not a member of the Insured Person's Immediate Family. An Insured Person will not be considered a Physician for care or treatment rendered to his/herself or his/her Immediate Family.

PHYSICIAN OFFICE VISIT means a direct personal contact between a Physician or other health care practitioner and an Insured Person in the health care practitioner’s office for diagnosis or treatment associated with the use of the appropriate office visit code.

PLAN YEAR if shown in the Schedule of Benefits means the period of time which begins immediately on the Employer’s Effective Date and ends each 12 months following the initial Effective Date. When a person first becomes an Insured Person, the first Plan Year begins on the Insured Person’s Effective Date and ends on the next following Employer’s anniversary date.

POLICYHOLDER OR GROUP POLICYHOLDER means the Employer identified as the Policyholder in the Schedule of Benefits.

PRE-AUTHORIZATION/PRIOR AUTHORIZATION means a screening process using established medical criteria to determine whether the proposed treatment plan is appropriate. It may include proposing alternative treatment plans, concurrent length of stay reviews, and discharge planning.

PREFERRED PROVIDER/IN-NETWORK PROVIDER means a Physician, Hospital or other health care Provider that is currently a member of a Preferred Provider Organization (PPO) network contracted with Us to provide medical services to Our Insureds. The PPO network is named on the ID card. You should, however, always check to be sure a listed Provider is still a participating member of the PPO network at the time medical services are needed. A toll-free number is provided on Your ID card to locate Preferred Providers or you can go to [www.aetna.com/docfind/custom/mymeritain][15]and input [Open Choice PPO][16] as Your plan.

PREGNANCY means the period following the receipt by an Employee, Dependent spouse, Dependent Domestic Partner or Dependent child of a diagnosis of Pregnancy until the discharge of the Employee, Dependent spouse, Dependent Domestic Partner or Dependent child from the Hospital or other Facility following the delivery of the newborn child.

PRESCRIPTION DRUG/PRESCRIPTION MEDICATION means any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

PREVENTIVE CARE SERVICES means the evaluation and management of an Insured Person including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures – when no symptoms exist and there is no diagnosis.

PROVIDER means a Physician, Hospital, or any other duly licensed institution or duly licensed individual providing medical or health services.

REASONABLE AND CUSTOMARY CHARGES means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred, so long as those charges are reasonable. The "most common charge" means the lesser of:

1. The actual amount charged by the Provider;
2. The negotiated rate;
3. The charge which would have been made by the Provider (Physician, Hospital, etc.) in the absence of insurance;
4. The charge which would have been made by the Provider for a comparable service or supply; or
5. The charge by other Providers in the same Geographic Area, for the same or comparable service or supply.

In determining whether a charge is reasonable, We may consider other factors, including but not limited to:

1. The complexity of service or supply involved;
2. The degree of professional skill, experience and training required for a Physician to perform the procedure or service;
3. The severity or nature of the condition being treated;
4. The Provider's adherence or failure to adhere to charging and practices generally accepted by an established United States medical society; and
5. The cost to the Provider of providing the service or supplies, or performing the procedure.

If the information above is not sufficient to determine whether a charge is reasonable for a Geographic Area, We may refer to National Data Bases reflecting Provider fee data.

REHABILITATION FACILITY means a legally operating institution or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, is duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services.

REHABILITATIVE SERVICES means treatment, services and supplies for the purpose of restoring bodily function.. These services may consist of physical therapy, occupational therapy, and speech therapy in an Inpatient and/or Outpatient setting. Care ceases to be Rehabilitative Services when either (i) the Insured Person can perform the activities which are normal for the same age and gender; or (ii) the Insured Person has reached the maximum therapeutic benefit and further Rehabilitative Services cannot restore further bodily function beyond the level the Insured Person currently possesses.

RESPITE CARE means short-term Inpatient care provided to an Insured Person only when necessary to relieve the family members or other persons caring for the Insured Person

RETIREE means any former Employee who is covered under a non-discriminatory, written retirement plan of the Employer that provides for benefits on the same terms and conditions as an Employee.

ROBOTIC ASSISTED SURGERY means technology by which the surgeon views the operative field via a terminal from cameras inserted into the body and manipulates robotic surgical instruments via a control panel.

SERVICE AREA means the area within the United States Including both In-Network and Out-Of-Network Providers.

SERVICE WAITING PERIOD means a period of time not more than 90 days from the date of hire that must pass with respect to an Employee before the Employee is eligible to be covered for benefits under the terms of the Group Policy. The Service Waiting Period is shown in the Schedule of Benefits.

SERVICES means health care services or items ("health care" includes both physical health care and mental health care).

SKILLED NURSING FACILITY means a facility that provides Inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term Skilled Nursing Facility does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily Custodial Care, including training in routines of daily living. A Skilled Nursing Facility may also be a unit or section within another facility (for example, a Hospital) as long as it continues to meet this definition.

SOUND NATURAL TEETH means teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

STABILIZE means to provide the medical treatment of an Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

SUBSTANCE USE DISORDER means alcoholism or Chemical Dependency. Refer to the Mental Health Conditions/Substance Use Disorders for the benefits.

TRANSPLANT NETWORK means a health services organization, designated as a Transplant Network by the Company, which has entered into an agreement with, or on behalf of, the Company, to render Medically Necessary and medically appropriate specialty services. A Transplant Network may or may not be located within an Insured Person’s Geographic Area. Services provided through a Transplant Network are coordinated by the Company.

URGENT CARE means medical care for a condition serious enough that a reasonable person would seek care right away, but not so severe as to require Hospital emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

URGENT CARE CENTER means a licensed facility (except Hospitals) that provides Urgent Care.

US, WE, OUR or COMPANY means National Health Insurance Company.

YEAR/YEARLY means Plan Year, which is the 12 month period beginning with the Employer’s effective date of coverage.

YOU, YOUR, YOURS means the Employee named in the Schedule of Benefits whose coverage has become effective with Us and has not terminated.

PART 2 – ELIGIBILITY FOR INSURANCE

A. Eligibility For Insurance

To be eligible for coverage under the Policy, an individual must either meet the definition of Employee or meet the definition of Dependent.

B. Employee Enrollment Eligibility

To become an Employee insured under the Policy, You must:

1. Be an Eligible Employee;
2. Complete and submit, through Your Employer, an Enrollment Form, during an enrollment period;
3. Provide any additional information We need to determine eligibility, if requested by Us; and
4. Agree to pay Your portion of the required premium, if required by the Employer.

C. Dependent Enrollment Eligibility

1. You may enroll Your current Dependent(s) at the same time You initially enroll.
2. You may enroll any new Dependent who meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer.

D. Employee And Dependent Enrollment Periods

There are three types of enrollment periods for obtaining coverage under the Policy:

1. The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. If You or Your Dependent are enrolling during the Initial Enrollment Period, the Initial Enrollment Period will be as follows:

   a. With respect to an Employee or Dependent at the time of the Initial Enrollment Period, You must submit an Enrollment Form within 31 days beginning on the initial date of Your eligibility. Your initial date of eligibility is the first day of Your Service Waiting Period, which is typically the date on which employment begins.

   b. If Your Dependent is a newborn child, who is born after the Initial Enrollment Period, he or she will automatically be covered for the first 31 days following birth, You must notify Us in writing within 60 days after the newborn child's birth and any additional premium for the child that is necessary to continue coverage beyond the initial 31 day period must be paid.

   c. If Your Dependent is an adopted child or child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, he or she will automatically be covered fo the first 31 days following the date of adoption or date of placement, You must notify Us in writing within 60 days after the date of adoption or date of placement for adoption and any additional premium for the child that is necessary to continue coverage beyond the initial 31 day period must be paid.

   d. If Your Dependent is a disabled child age 26 or over at the time of the initial enrollment, We will continue to provide coverage for the child and allow You 60 days to respond to requests for evidence of disability. Thereafter, We my request eligibility information not more frequently than annually, and You will have 60 days to submit the requested information.

   For the continued enrollment of a disabled child who reaches age 26, We will notify You at least 90 days before the child attains age 26 and allow You to provide satisfactory evidence of disability during the period commencing 60 days before and ending 60 days after the child's 26th birthday. We will continue coverage until We make a determination as to the child's disability and dependency. Thereafter, following the disabled child's 28th birthday and no more often than annually thereafter, We may request that You provide satisfactory evidence of the child's disability, and You will have 60 days to respond." Newborn or newly adopted children enrolled within 60 days of birth or placement will be treated as continuously enrolled from the time of birth or placement. If the child is not enrolled within the first 60 days, that child may not be added as a Dependent to the policy (except for automatic coverage for first 31 days following birth or placement) until the next open enrollment period, unless he or she experiences one of the other triggering events for another special enrollment period.

2. If You or Your Dependent have a Special Enrollment Period the length of the Special Enrollment Period during which You and/or Your Dependent may submit an Enrollment Form is 60 days beginning on the date of the termination of coverage or the date on which the employer contributions end.

   A special Enrollment Period includes the following:

   a. Coverage is provided to a dependent in the court ordered custody of an Insured Person on the same basis and to the same extent, and in the same manner, as for a newborn Dependent.

      We must receive notification within 60 days of the date on which the court order establishing custody of the child by the Insured Person was issued and any additional premiums that are due for the coverage of the child must be paid. In order to establish court ordered custody, the Insured Person must send to Us a copy of the court order that establishes that the Insured Person has full legal custody of such child.

   b. If You are an eligible Employee who waived coverage during the Initial Enrollment Period and get married after the Initial Enrollment Period, You may enroll both Yourself, Your newly eligible spouse or Domestic Partner, any of Your children and any of Your spouse's children or Your Domestic Partner's children by submitting an Enrollment Form within the first 60 days from the date of marriage or domestic partnership.

   c. You or Your Dependent lose "minimum essential coverage" as defined in 26 U.S.C. Section 5000A(f) which includes individual health policies, employment-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage, except for failure to pay the required premium on a timely basis on situations allowing for a rescission.

   d. You or Your Dependent has been released from incarceration.

   e. You or Your Dependent's health coverage issuer substantially violated a material provision of the health coverage contract.

   f. You or Your Dependent gains access to coverage under the Policy as a result of a permanent move.

   g. You or Your Dependent is receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 or Section 1399.845 of the California Health and Safety Code for (1) an acute condition, (2) a serious chronic condition, (3) a pregnancy, (4) a terminal illness, (5) the care of a newborn child between birth and age 36 months, or (6) performance of a surgery or other procedure that has been recommended and documented by the Provider to occur within 180 days of the contract's termination date, and that Provider is no longer participating in the health benefit plan. For additional information about these conditions, please see PART 3 – MEDICAL MANAGEMENT, Provider Network.

   h. You or Your Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

   i. You or Your Dependent demonstrates to the Department of Insurance that You or Your Dependent did not enroll in a health benefit plan during the immediately preceding enrollment period because of misinformation regarding coverage under "minimum essential coverage".

   j. The Employee gains a Dependent or becomes a Dependent

   We must receive notification within 60 days of the date any of the events in items c-h above occurred and any additional premiums that are due for the coverage of the Dependent must be paid.

3. You or Your Dependent may enroll under the Policy during the Annual Open Enrollment Period shown on the Schedule of Benefits. If You or Your Eligible Dependents do not enroll during the Initial Enrollment Period or during a Special Enrollment Period as described above, You must wait until the next Annual Open Enrollment Period to enroll.

E. Employee Effective Date

Your Effective Date of coverage under the Policy will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date.
2. If You become eligible after the Employer's Effective Date and enroll during an Initial Enrollment Period, coverage will be effective on the first day of the month preceding the last day of Your Service Waiting Period.
3. If you become eligible after the Employer's Effective Date and enroll during a Special Enrollment Period coverage will be effective on the first day of the month following receipt of the enrollment form by Us.
4. If You enroll for coverage during the annual open enrollment period shown on the Schedule of Benefits, Your coverage will be effective on the first day of the month following the Open Enrollment Period or the first day of the month following the day on which We receive the enrollment form, whichever is later..

F. Dependent Effective Date

The Effective Date of a Dependent's coverage under the Policy depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;
2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;
3. If the Dependent is a new spouse or Domestic Partner who first becomes eligible after Your Effective Date and You timely enroll the new spouse or Domestic Partner as described above, coverage will become effective as of the first day of the month following the date on which We receive the enrollment form;
4. If the Dependent is a newborn child who is born after Your Effective Date, the newborn child is automatically covered for the first 31 days from and after the moment of birth. Coverage for Your newborn child will continue effective as of the date of birth if You timely enroll the Dependent as described above.
5. If the Dependent is an adopted child or a child placed for adoption who is adopted or placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or placement for adoption; or
6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after the Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the first day of the month following the date on which We receive the Enrollment Form; or
7. If Your Eligible Dependent enrolls for coverage during the annual open enrollment period shown on the Schedule of Benefits, coverage for Your Eligible Dependent will be effective on the first day of the month following the Open Enrollment Period or the first day of the month following the day on which We receive the enrollment form, whichever is later.

Services or supplies that are payable as Covered Charges under the Policy are covered from the Effective Date; *provided however*, services or supplies for a condition that is covered under an extension of benefits from previous health insurance coverage or other benefit arrangement will not be covered under the Policy until the extension of benefits under the prior health insurance coverage or benefit arrangement ends.

HEALTH CARE COORDINATION

Health Care Coordination is the Policy program conducted by the Health Care Coordinator, [American Health Holding, Inc.][14], designated by Us which:

A. Identifies cases involving the Insured Person in a clinical situation with the potential for catastrophic claims;
B. Assesses those cases for the appropriate level of patient care and the setting in which it is received;
C. Develops, introduces and implements viable Alternate Treatment Plans for those cases that maintain or enhance the quality of patient care; and
D. Provides cost controls by implementing the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Health Care Coordinator in charge of the case receiving Health Care Coordination. This document is developed through discussion and agreement with the Insured Person or legal guardian (if necessary), the attending Physician and Us. It includes:

A. Treatment Plan objectives;
B. Course of treatment planned to accomplish those objectives;
C. Responsibility of each party (Health Care Coordinator, attending Physician and Insured Person and his Family, if any) in implementing the plan; and
D. Estimated cost and savings.

If We agree with the Health Care Coordinator, the attending Physician and Insured Person on an Alternate Treatment Plan, We may pay incurred Eligible Expenses at a higher Coinsurance Percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Eligible Expense under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall require written approval by Us. If written approval is granted, payment of benefits under the Policy for those services or supplies shall be on the same basis as if those services or supplies were Eligible Expense.

NO INSURED PERSON IS REQUIRED TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE HEALTH CARE COORDINATOR**.**

PROVIDER NETWORKS

NETWORK ACCESS – Warning Regarding Limitations on Network Provider Services

Reimbursement for Covered Charges varies depending on the Provider that the Insured Person selects to provide treatment, services or supplies. An In-Network Provider has affiliated with an organization, association or entity, such as a preferred Provider organization or managed care organization that has established a network of Providers in a specific Geographic Area to provide medical treatment, services and supplies at predetermined rates. An Out-of-Network Provider is a Provider who is not participating in Your Provider network. We make available selected Network(s) to provide an Insured Person an opportunity to select an In-Network Provider for treatment, services or supplies. Your Employer selects the Provider network on behalf of all Employees. If an Insured Person uses an In-Network Provider, We will pay benefits for that treatment, service or supply at the In-Network Provider benefit level as specified in the Schedule of Benefits. If treatment, services or supplies are obtained or received from an Out-Of-Network Provider, unless otherwise stated herein, the following applies: (i) Covered Charges will be reimbursed at the Out-Of-Network Benefit Level; (ii) Charges will be reduced to the Reasonable and Customary Charges for such treatment, service or supply before being considered a Covered Charge; and (iii) the Insured Person will be responsible for any portion of the charges that exceed the Reasonable and Customary Charges for such treatment, service or supply.

No coverage is provided outside the Service Area except for emergency health care services.

We will not penalize an Insured Person or subject an Insured Person to the Out-of-Network level of benefits unless In-Network Providers are reasonably available to the Insured Person without unreasonable delay.

A current directory of network providers can be found at [www.aetna.com/docfind/custom/mymeritain][15].

Insured Persons who have complaints regarding their ability to access needed medical care in a timely manner may complain to Us and to the California Department of Insurance. Our address and customer service telephone number are: National Health Insurance Company, c/o Meritain Health, [1405 Xenium Lane North Ste 140; Minneapolis, MN 55441 1-800-847-8361.][5] The address and toll free telephone number of the Consumer Services Division of the Department of Insurance is: 300 South Spring Street; Los Angeles, CA 90013 1-800-927-HELP, TDD: 800-482-4TDD. The web address is (www.insurance.ca.gov).

We will notify You not later than 30 days after Our receipt of termination from an In-Network Provider.

CONTINUITY OF CARE

Upon termination of an In-Network Provider contract, at the request of the Insured Person, We will pay for Covered Charges rendered by such Provider to the Insured Person after the date of termination if the Insured Person is undergoing a course of treatment for any of the following conditions:

A. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms and requires prompt medical attention or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for the duration of the acute condition.
B. A serious chronic condition. A serious chronic condition that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Insured Person and the terminated Provider and consistent with good professional practice. Completion of covered services will not exceed 12 months from the contract termination date.
C. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
D. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date.
E. The care of a newborn child between birth and age 36 months. Completion of covered services will not exceed 12 months from the contract termination date.
F. Performance of a surgery or other procedure that has been recommended and documented by the Provider to occur within 180 days of the contract's termination date.

We may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, Hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, We are not required to continue the Provider's services beyond the contract termination date.

The rate of payment for Covered Charges under this paragraph will be the rate of payment for the same services of the Provider while under contract with Us at the time of termination of the contract with the exception of any applicable Cost-Sharing. The Provider must accept the reimbursement as payment in full and may not balance bill the Insured Person.

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In-Network benefit level shown in the Schedule of Benefits, until the Insured Person is stabilized and can be safely transported to an In-Network Provider as determined by the utilization review manager and the attending Physician. Otherwise, benefits will be reduced to the Out-of-Network Coinsurance Percentage shown in the Schedule of Benefits.

When non-emergency Covered Charges are incurred from an In-Network health facility and the Insured Person receives services from an Out of Network Provider without informed consent as specified, benefits will be paid at the In-Network benefit level shown in the Schedule of Benefits. Cost Sharing will count towards the limit on the In-Network annual Out-Of-Pocket Maximum and apply towards the In-Network Deductible.

The informed consent must be in writing and must demonstrate satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the Insured Person will consent in writing to receive services from the identified Out-of-Network Provider.

(2) The consent shall be obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the Insured Person is being prepared for surgery or any other procedure.

(3) At the time consent is provided the Out-of-Network Provider shall give the Insured Person a written estimate of the Insured Person's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving separate written consent from the Insured Person or the Insured Person's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent will advise the Insured Person that he or she will elect to seek care from an In-Network Provider or may contact Us in order to arrange to receive the health service from an In-Network Provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the Insured Person in the language spoken by the Insured Person, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the Health and Safety Code.

(6) The consent shall also advise the Insured Person that any costs incurred as a result of the Insured Person's use of the Out-of-Network benefit will be in addition to In-Network cost-sharing amounts and will not count toward the annual Out-of-Pocket maximum on In-Network benefits or a Deductible, if any, for In-Network benefits.

We do not arrange or provide treatment, services or supplies except as stated above regarding termination of a Provider. It is always the Insured Person's responsibility to select a health care Provider of their choice. We have no control over, and are not responsible for, the actions or lack of actions of any Provider or Provider organization pertaining to any treatment, services or supplies rendered to an Insured Person. The list of In-Network providers can be found on the website: [www.aetna.com/docfind/custom/mymeritain][15].

PRE-AUTHORIZATION PROGRAM

The Pre-Authorization Program is a prospective review that allows Us to determine whether the medical care or health care services proposed to be provided to the Insured Person are Medically Necessary and appropriate. The Pre-Authorization Program includes a list of certain medical care and health care services that require preauthorization as a condition of Our payment to a Provider under the Policy without a penalty. On receipt of a request from a Provider for Pre-Authorization, We will review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination will be issued and transmitted not later than the third calendar day after the date the request is received by Us. When We have pre-authorized medical care or health care services, We will not deny or reduce payment to the Physician or health care Provider for those services based on Medical Necessity or appropriateness of care unless the Physician or Provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services. The Pre-Authorization penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or other specified medical care or health care services when the Insured Person does not comply with Pre-Authorization. A penalty will only be charged if the Covered Charge is determined to be Medically Necessary after the medical care or health care service is received. The Pre-Authorization penalty amount is in addition to the applicable Yearly Deductible Copay and Coinsurance and does accumulate toward the Out-of-Pocket Maximum. If the Insured Person complies with Pre-Authorization, the Pre-Authorization penalty amount will not apply. Pre-Authorization is required of all proposed Inpatient Confinements for more than 23 hours. Pre-Authorization is also required of proposed medical care and health care services, as specified in the Schedule of Benefits.

Timeline for non-urgent prior authorization determination: Decisions to approve, modify, or deny, based on medical necessity, requests by Providers prior to, or concurrent with, the provision of health care services to an Insured Person will be made in a timely fashion appropriate for the nature of the Insured Person's condition, not to exceed 5 business days from Our receipt of the information reasonably necessary and requested by Us to make the determination.

Timeline for urgent prior authorization determination: When an Insured Person's condition is such that the Insured Person faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, 5 business days, would be detrimental to the Insured Person's life or health or could jeopardize the Insured Person's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health

care services to an Insured Person will be made in a timely fashion, appropriate for the nature of the Insured Person's condition, but not to exceed 72 hours.

Timeline for retrospective medical necessity review: The decision shall be communicated to the Insured Person who received services, or to the Insured Person's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and will be communicated to the Provider in a manner that is consistent with current law.

To request Pre-Authorization, the Insured Person or the Insured Person's attending Physician must contact [American Health Holding, Inc.] at least 48 hours prior to obtaining the requested treatment, service or supply. [American Health Holding, Inc.]may be reached by writing; or by telephone during normal business hours each business day. The Insured Person will be requested to provide:

A. Name, address and the telephone number of the attending Physician;

B. The proposed treatment plan;

C. The Insured Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

[American Health Holding, Inc.]will then consult with the Insured Person's attending Physician. If [American Health Holding, Inc.]concurs with the Insured Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, [American Health Holding, Inc.]will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Authorization requirement described herein.

American Health Holding, Inc.]may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring an Insured Person's progress on a daily basis to determine if the Insured Person will be discharged within the pre-authorized number of days and to determine the appropriate number of additional days of stay that may be required according to the Insured Person's condition and plan of treatment. Hospital admissions will be monitored to assure that the Insured Person will be discharged timely. The attending Physician and the Hospital utilization review nurses will be contacted to determine the progress of the Insured Person and the need, if any, for an extension of authorized Hospital days. If an extension of the Inpatient stay is not authorized for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

In absence of Pre-Authorization, benefits are subject to the penalty as specified in Your Schedule of Benefits. A penalty will only be charged if the Covered Charge is determined to be Medically Necessary after it is received.

Pre-Authorization is not a guarantee of payment; however, We will not deny or reduce payment to the Physician or Provider for those Covered Charges that are Pre-Authorized based on Medical Necessity or appropriateness of care. Payment of benefits is subject to all the terms, conditions, limitations and exclusions of the Policy. Pre-Authorization does not include a determination of whether the proposed services are covered under the Policy.

If [American Health Holding, Inc.]does not concur with the Insured Person's Physician, [American Health Holding, Inc.] will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the Pre-Authorization requirement described herein and the penalty or limitation on extended number of days will apply.

Pre-Authorization is not required for mastectomy and lymph node dissection hospital stays.

PRE-AUTHORIZATION OF EMERGENCY INPATIENT CARE

The Insured Person or the Insured Person's Physician may notify [American Health Holding, Inc.]of the Emergency Inpatient confinement within 48 hours of the Inpatient Admission or as soon as reasonably possible and be in compliance with the Pre-Authorization requirement.

If an Insured Person goes to an Out-Of-Network Provider Hospital for an Emergency Medical Condition, Inpatient Hospital Confinement benefits will be paid by Us at the In-Network level of benefit as specified in the Schedule of Benefits. However, the Insured Person must arrange transfer to an In-Network Hospital within 48 hours, or as soon as the transfer may take place without detriment to the Insured Person's health. Benefits for Out-of-Network Emergency Services are payable in an amount equal to the amount for the Emergency Service calculated using the Reasonable and Customary Charge. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level.

PRE-AUTHORIZATION OF PREGNANCY

You are not required to obtain Pre-Authorization for Pregnancy or for a post-delivery Inpatient confinement of 48 hours or less for a vaginal delivery or 96 hours or less for delivery by Cesarean Section.

If, following delivery, Your Physician determines that You need to remain confined in a Hospital for more than 48 hours following vaginal delivery or 96 hours following delivery by Cesarean Section, You or Your Physician must notify [American Health Holding, Inc.] of the continuing Hospital Inpatient confinement as soon as reasonably possible following the determination to continue Your Hospital Inpatient Confinement.

PRE-AUTHORIZATION OF OTHER NON EMERGENCY MEDICAL CARE OR HEALTH CARE SERVICES

Pre-Authorization is required in order to receive benefits for the care, treatment and services as listed in the schedule of benefits without a penalty. The Insured Person is responsible for assuring that the required Pre-Authorization is received before the charges are incurred by calling the [American Health Holding, Inc.]. Failure to comply with the Pre-Authorization requirement will result in assessment of the penalty shown in the Schedule of Benefits.

The Insured Person must obtain Pre-Authorization for other non-emergency medical care or health care services, as shown in the Schedule of Benefits.

If Pre-Authorization is approved for a particular treatment or service, that authorization applies only to the Medical Necessity of that treatment or service. Payment of benefits for all treatments or services is subject to the terms, conditions, limitations and exclusions of the Policy.

SURROGACY ARRANGEMENTS

If You enter into a surrogacy arrangement, You must pay Us charges for covered Services You receive related to conception, Pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount You must pay will not exceed the compensation You are entitled to receive under the Surrogacy Arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This Surrogacy Arrangements paragraph does not affect Your obligation to pay Cost Sharing for these Services, but We will credit any such payments toward the amount You must pay Us under this paragraph.

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or Your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments. Those payments shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, You must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

National Health Insurance Company [c/o Meritain Health
1405 Xenium Lane North Ste 140; Minneapolis, MN 55441][17]

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights We may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce Our rights under this provision without Our prior, written consent.

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to Our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign Our rights to enforce Our liens and other rights.

PART 4 – BENEFIT PROVISIONS

We will pay Covered Charges incurred in the Service Area; no coverage is provided outside the Service Area except for emergency health care services. Covered Charges may during a Year, be subject to Copays, the Deductible, Coinsurance Percentage and Out-of-Pocket Maximum, shown in the Schedule of Benefits. Covered Charges must be incurred while this coverage is in force, and are subject to the terms, conditions, limitations, exclusions, and maximums stated in the Policy, this Certificate and the Schedule of Benefits.

In-Network. Covered Charges incurred from Preferred Providers will be paid according to the Copay, Deductible, Coinsurance Percentage, and Out-of-Pocket Maximum shown in the Schedule of Benefits for In-Network Services, and will be based on the Negotiated Rate.

Out-of-Network. Covered Charges incurred from an Out-of-Network Provider will be paid according to the Deductible, Coinsurance Percentage, and Out-of-Pocket Maximum shown in the Schedule of Benefits for Out-of-Network services, and will be based on Reasonable and Customary Charges.

BENEFITS MAY BE REDUCED OR EXCLUDED WHEN SERVICES ARE RECEIVED OUT-OF-NETWORK. THIS MAY ALSO INCLUDE AN ADDITIONAL DEDUCTIBLE, REDUCED COINSURANCE PERCENTAGE AND A HIGHER COPAY.

Using Your ID Card. Your ID card identifies You as an Insured Person in the PPO program. You are responsible for showing Your ID card to the Provider at the time of service.

Use Any Provider You Choose. You are not required to seek treatment from a PPO Provider. Each Insured Person is free to elect the services of any Provider and benefits payable will be in accordance with the terms and conditions of Your coverage under the Policy.

We do not represent Physicians or warrant the medical competence or ability of a PPO Provider, or their respective staff, nor do We have any liability or responsibility for any actions or inactions of a PPO Provider or their staff.

Deductibles. The Deductibles listed in the Schedule of Benefits will apply only once during a Year.

PART 5 – COVERED CHARGES

Covered Charges are the Negotiated Rate or those Reasonable and Customary Charges incurred for services and supplies listed below which are Medically Necessary. A Covered Charge is "incurred" on the date the service or treatment is provided or the supply is obtained. Covered Charges must be incurred while Your coverage is in force. The following benefits are paid for Covered Charges at the levels indicated in the Schedule of Benefits.

1. INPATIENT FACILITY SERVICES

Benefits are payable for the following Inpatient Hospital Services:

A. Room, board and general nursing service, when You occupy:

1) A Hospital room with 2 or more beds, known as a semi-private room or ward; or
2) A private room. The amount of benefits for a private room is limited to the Hospital's semi-private room rate, or if there is no semi-private room rate, 90% of the private room rate except that 100% of the private room rate is a Covered Charge if a private room is the only room available or is Medically Necessary; or
3) A bed in a special care unit. A special care unit is a unit whose main purpose is to provide an intensive level of care for critically ill patients. Examples of a special care unit are a coronary care unit or an Intensive Care Unit.

B. Miscellaneous Services and Supplies. Examples include:

1) Use of operating, and treatment rooms, and equipment;
2) Drugs (excluding take home drugs);
3) Administration of blood and blood processing (including the cost of blood, plasma or fractionalized blood products);
4) Anesthesia, anesthesia supplies and services;
5) Medical and surgical dressings, supplies, casts, and splints;
6) Diagnostic services;
7) Therapy services;
8) Nursing services in a special care unit, other than the portion payable under Section 1 above; and
9) One visit per Physician per day during a covered Hospital confinement.

2. SURGICAL SERVICES

Benefits are payable as specified in the Schedule of Benefits if You require surgery. The surgery must be performed in a Hospital, Hospital Outpatient department or Ambulatory Surgical Center or Physician office. The following services are eligible for coverage:

A. **Surgical Services.** Services must be performed by a Physician. Additional payment will not be made for related pre- and post- operative care billed separately by the Physician which would or should be customarily included as part of the fee for the surgery. Benefits for surgical services will be paid as follows:

1) **Single Surgical Services.** When a single surgical service is provided by 2 or more Physicians, the benefit will be the same as if the surgical care was rendered by one Physician.
2) **Multiple Surgical Services.** The benefit payable if 2 or more surgical services are performed at the same time through different openings or approaches, is the sum of the following amounts: the greatest Covered Charge for one of the surgical procedures, plus one-half of the Covered Charge for each of the other surgical services performed.
3) **Physician Office Surgery (Major)**
This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.
4) **Physician Office Surgery (Minor)**
This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.

B. **Surgical Assistant.** Services of a Physician who actively assists the operating surgeon in the performance of surgery are covered. The benefit payable will not exceed 20% of the benefit amount payable for the primary surgeon's fee. No coverage will be provided for a Physician on call or placed on standby.

C. **Anesthesia.** Benefits are payable for the administration of anesthesia ordered by the attending Physician and rendered by a Physician in connection with a covered service. If a Certified Registered Nurse Anesthetist (CRNA) is utilized, total benefits for the Anesthesiologists and the CRNA will be limited to the Reasonable and Customary amount of the Anesthesiologist for the anesthesia service. If the only charge submitted for payment is for the services of a CRNA, then benefits will be limited to the Reasonable and Customary Charge of a CRNA for the anesthesia service.

D. **Miscellaneous Services.** Benefits are payable for Covered Charges for the following services provided and supplies obtained in the course of receiving surgical services.

1) The processing and administration of blood and blood components, and for whole blood, blood plasma and blood products that are not replaced by a donor for an Insured Person;
2) Heart pacemaker;
3) Medical and surgical dressings, casts, splints, braces, and crutches;
4) Oxygen and other gases, as well as charges for their administration;
5) Nursing services in an Ambulatory Surgical Center; or
6) The use of operating and treatment rooms, and equipment, in an Ambulatory Surgical Center.

3. PHYSICIAN OFFICE VISITS

Benefits are payable for Physician Office Visits.

In-Network Physician Office charges for examination, consultations, evaluation or consultation will be subject only to the Physician Office Visit Copay amount, limited to one office visit per day. However, charges for other treatment received during a Physician Office Visit are subject to the In-Network Deductible, Coinsurance Percentage and Out-of-Pocket Maximum.

Out-of-Network charges will be subject to the Out-of-Network Deductible, Coinsurance Percentage, and Out-of-Pocket Maximum shown in the Schedule of Benefits.

4. ORGAN, TISSUE, AND BONE MARROW TRANSPLANTS

Benefits are payable for organ transplant or tissue transplant or replacement. However, the only organ transplants considered to be Covered Charges are those that are not Experimental or Investigational. If we deny coverage for transplant services based on a determination by us that the services are Experimental or Investigational, you may request an independent review of that decision. Please refer to the Independent Medical Review Process under Part 13 for more information."

An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person's transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

If the Insured Person receives a covered organ or tissue transplant, the donor's expenses will be considered to be the Insured Person's expenses even if the donor is also insured under the Policy as an Employee or Dependent. We will pay

benefits for the donor's Covered Charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor.

Benefits are payable for living transplant donors, We provide certain donation-related services for a donor, or an individual identified by Us as a potential donor, whether or not the donor is an Insured Person. These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications.

We will not deny coverage under this Benefit for the costs of solid organ or other tissue transplant services based on the Insured Person being infected with the human immunodeficiency virus.

5. DIAGNOSTIC TESTING SERVICES –Minor

Benefits are payable for diagnostic tests including related professional fees, incurred on a non-Inpatient basis. Diagnostic tests include,: x-rays, laboratory tests, electrocardiograms (EKGs) and electroencephalograms (EEGs).

6. SPECIALTY DIAGNOSTIC SERVICES – Major

Benefits are payable for specialty diagnostic tests, and including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

7. REHABILITATIVE SERVICES

Benefits are payable for Rehabilitative Services including physical, occupational or speech therapy, when ordered by a Physician and provided by a licensed or registered therapist or physiatrist. Behavioral health treatment for pervasive developmental disorder or autism may be provided by a qualified autism service provider, professional, or paraprofessional. We will evaluate the Medical Necessity of Rehabilitative Services by monitoring progress toward expected outcomes.

8. HABILITATIVE SERVICES

Benefits are payable for Habilitative Services, including occupational, speech and physical therapies and behavioral health treatment for pervasive developmental disorder or autism, under the same terms and conditions as described for Rehabilitative Services immediately above in this Certificate.

9. OUTPATIENT MEDICAL THERAPY

Benefits are payable for facility charges and professional fees incurred for radiation therapy, including treatment planning, chemotherapy, and hemodialysis therapy for treatment following a covered Hospital confinement or a covered Outpatient surgery.

10. ALLERGY SERVICES

Benefits are payable for allergy testing and allergy injections.

11. PROSTHETIC AND ORTHOTIC DEVICES

Benefits are payable for prosthetic and orthotic devices if all of the following requirements are met:

A. The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes; and
B. The device is the standard device that adequately meets the Insured Person's medical needs.

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and Services to determine whether the Insured Person needs a prosthetic or orthotic device. If We cover a replacement device, then the Insured Person must pay the Cost Sharing for obtaining that device.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, only if they are implanted during a surgery that We are covering under the Policy.

External devices

We cover the following external prosthetic and orthotic devices:

A. Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices);
B. Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months;
C. Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Provider who is a podiatrist;
D. Compression burn garments and lymphedema wraps and garments;
E. Enteral formula for Insured Persons who require tube feeding in accordance with Medicare guidelines;
F. Prostheses to replace all or part of an external facial body part that has been removed or impaired.

12. RECONSTRUCTIVE SURGERY

Benefits are payable for the following reconstructive surgery Services:

A. Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
B. Following Medically Necessary removal of all or part of a breast, We cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

13. DIABETES EQUIPMENT AND SUPPLIES

Benefits are payable for Diabetes equipment and supplies for which a Physician has written an order including but not limited to:

A. Blood glucose monitors, including non-invasive monitors and monitors designed to be used by or adapted for the legally blind;
B. Test strips specified for use with a corresponding glucose monitor;
C. Lancets and lancet devices;
D. Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
E. Insulin and insulin analog preparations;
F. Injection aids, including devices used to assist with insulin injection and needleless systems;
G. Insulin syringes including pen delivery systems for the administration of insulin;
H. Biohazard disposal containers;
I. Insulin pumps, both external and implantable, and associated appurtenances, which include:
    1) Insulin infusion devices;
    2) Batteries;
    3) Skin preparation items;
    4) Adhesive supplies;
    5) Infusion sets;
    6) Insulin cartridges;
    7) Durable and disposable devices to assist in the injection of insulin; and
    8) Other required disposable supplies;
J. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
K. Prescription Medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
L. Podiatric appliances for the prevention of complications associated with diabetes;
M. visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin; and
N. Glucagon emergency kits.

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

All supplies, including medications, and equipment for the control of diabetes must be dispensed as written, including brand name products, unless substitution is approved by the Physician who issues the written order for the supplies or equipment.

14. DIABETES SELF-MANAGEMENT TRAINING
Benefits are payable for diabetes outpatient self-management training, education and medical nutrition therapy necessary to enable an Insured Person to properly use the equipment, supplies, and medications set forth in the Diabetes Equipment and Supplies Benefit and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the insured Person's Physician. Diabetes outpatient self-management training, education, and medical nutrition therapy services must be provided by appropriately licensed or registered health care professionals as prescribed by a health care professional legally authorized to prescribe the services.

15. PREGNANCY/MATERNITY
Benefits are payable for maternity services provided to an Insured Employee and Dependent.

Coverage includes treatment, services or supplies furnished in connection with a routine Pregnancy and delivery by elective cesarean section for:

A. A minimum of forty-eight (48) hours after an uncomplicated vaginal delivery; or
B. A minimum of ninety-six (96) hours after delivery by uncomplicated cesarean section.

The length of stay may be shortened at the discretion of the attending Physician after conferring with the mother.

This benefit includes routine well newborn nursery care while the newborn is Hospital-confined immediately after birth and includes room, board and other normal care for which a Hospital makes a charge.

This benefit also includes participation in the California Prenatal Screening program, which is a statewide prenatal testing program administered by the state Department of Health Services. There is no charge for this service

16. COMPLICATIONS OF PREGNANCY
Benefits are payable for Complications of Pregnancy in the same manner and to the same extent as for any other benefits covered under the Policy.

17. MENTAL HEALTH CONDITIONS/SUBSTANCE USE DISORDERS
Benefits are payable for, Inpatient Services, Outpatient Office Visits and Other Outpatient items and Services for Mental Health Conditions when provided by Physicians or other Providers who are licensed health care professionals acting within the scope of their license.

Benefits are payable for Inpatient Services, Outpatient Office Visits and Other Outpatient items and Services for treatment of Substance Use Disorders.

Benefits are payable for the diagnosis and all Medically Necessary treatment for Severe Mental Illness of a person of any age and Serious Emotional Disturbance of A Child.

Benefits are payable for methadone maintenance treatment.

Inpatient Services, including the following:
A. Inpatient hospitalization. Coverage includes room and board, drugs, and Services of Physicians and other Providers who are licensed health care professionals acting within the scope of their license.
B. Short-term treatment in a crisis residential program in a licensed treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute crisis.
C. Medical management of withdrawal symptoms, including room and board, Physician Services, drugs, dependency recovery Services, education, and counseling.
D. Treatment of Substance Use Disorders in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.
E. Rehabilitation & Habilitation services

Outpatient Office Visits, including the following:
A. Individual and group psychotherapy
C. Psychiatric diagnostic interviews
D. Individual and group chemical dependency evaluation and counseling.

Other Outpatient items and Services, including the following:

A. Short-term Hospital-based intensive Outpatient care (partial hospitalization);
B. Short-term multidisciplinary treatment in an intensive Outpatient treatment program;
C. Observation for an acute psychiatric crisis.
D. Day treatment programs
E. Intensive outpatient programs including Rehabilitation & Habilitation services
F. Behavioral health treatment for PDD/autism delivered at home
G. Pharmacologic management
H. Diagnostic psychological and neuropsychological tests
I. Electroconvulsive therapy (ECT)
J. Transcranial Magnetic Stimulation (TMS)
K. Narcosynthesis
L. Biofeedback therapy
M. Medical treatment for withdrawal symptoms

18. DENTAL ANESTHESIA

Benefits are payable for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center setting, when the clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Ambulatory Surgical Center, for children below the age of 7 years, persons who are developmentally disabled regardless of age, and persons whose health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Charges for the dental procedure itself (including the professional fee of the dentist) are not covered; except for pediatric dental benefits.

19. AMBULANCE SERVICES

Benefits are payable, as shown in the Schedule of Benefits, for a local, professional ambulance service to and from the nearest available Hospital or other medical facility which is appropriately staffed and equipped to treat the Insured Person's Emergency Medical Condition.

Transportation undertaken to secure treatment by a personal Physician or by a Physician or institution of greater renown or greater specialization is not covered. Preauthorization is required for non-emergency licensed ambulance services to transport an Insured. Services must be Medically Necessary and appropriate.

Benefits payable for nonemergency ambulance and psychiatric transport van services as shown in the Schedule of Benefits if a Physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services.

Benefits will not be payable for transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Provider

20. EMERGENCY SERVICES

Benefits are payable for Emergency Services directly provided by a health care Provider to treat an Insured Person’s Emergency Medical Condition. Emergency Services do not require Pre-Authorization. Emergency Services for a Covered Charge received by an Out-of-Network Provider will be paid at the In-Network Provider benefit level subject to the same Cost Sharing requirements, such as Deductible, Copay and Coinsurance requirements that would otherwise apply as if the Emergency Services were provided by an In-Network Provider.

The Emergency Services Copay applies as shown in the Schedule of Benefits.

21. URGENT CARE

Benefits are payable for Urgent Care directly provided by a health care Provider to treat medical care for a condition serious enough that a reasonable person would seek care right away, but not so severe as to require Hospital emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

22. SKILLED NURSING FACILITY SERVICES

Benefits are payable for skilled Inpatient Services in a Skilled Nursing Facility during a benefit period as shown on the Schedule of Benefits. The skilled Inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of Custodial or intermediate Care.

A benefit period begins on the date You are admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date You have not been an Inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care Hospital is not required.

We cover the following Services:

A. Physician and nursing Services;
B. Room and board ;
C. Drugs prescribed by a Physician as part of Your plan of care in the Skilled Nursing Facility if they are administered to an Insured Person in the Skilled Nursing Facility by medical personnel;
D. Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment;
E. Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide;
F. Medical social services;
G. Blood, blood products, and their administration;
H. Medical supplies;
I. Physical, occupational, and speech therapy;
J. Respiratory therapy.

23. HOME HEALTH CARE

Benefits are payable for Home Health Care only if all of the following are true:

A. The Insured Person is substantially confined to his or her home (or a friend's or relative's home);
B. The Insured Person's condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless the Insured Person is also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed Provider can provide); and
C. A Physician determines that it is feasible to maintain effective supervision and control of the Insured Person's care in his or her home and that the Services can be safely and effectively provided in his or her home.

We cover only part-time or intermittent home health care, as follows:

A. Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide;
B. Up to three visits per day (counting all home health visits); and
C. Up to the number of visits per Year (counting all home health visits) shown on the Schedule of Benefits. Separate visit limits will apply to Rehabilitative and Habilitative services as shown on the Schedule of Benefits.

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to an Insured Person's home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at the Insured Person's home during the same two hours, that counts as two visits.

Coverage for Services related to "Home Health Care" described in other sections.

Coverage for the following Services is described under these headings in this section:

Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment ")

Dialysis care (refer to "Dialysis Care")

Durable medical equipment (refer to "Durable Medical Equipment")

Ostomy and urological supplies (refer to "Ostomy and Urological Incontinence Supplies")

Outpatient drugs, supplies, and supplements (refer to " Prescription Drugs and Medicines")

Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

24. HOSPICE SERVICES AND RESPITE CARE

Benefits are payable for Hospice Services listed below if all of the following requirements are met:

A. A Physician has diagnosed the Insured Person with a Terminal Illness and determines that the Insured Person's life expectancy is 12 months or less;
B. The Services are provided by a licensed Hospice Care agency; and
C. The Services are necessary for the palliation and management of an Insured Person's Terminal Illness and related conditions.

Benefits are payable if the Hospice:

A. Considers the Insured Person and the Insured Person's family, in addition to the Insured Person, as the unit of care.
B. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Insured Person and the Insured Person's family.

C. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Insured Persons who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
D. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
E. Provides for bereavement services following the Insured Person's death to assist the family to cope with social and emotional needs associated with the death of the Insured Person.
F. Actively utilizes volunteers in the delivery of Hospice services.
G. To the extent appropriate based on the medical needs of the Insured Person, provides services in the Insured Person's home or primary place of residence.

If all of the above requirements are met, We cover the following Hospice Services, which are available on a 24-hour basis if necessary for the Insured Person's Hospice Care:

A. Physician Services;
B. Skilled Nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to You and Your family, and instruction to caregivers;
C. Physical, occupational, or speech therapy for purposes of symptom control or to enable You to maintain activities of daily living;
D. Respiratory therapy;
E. Medical Social Services;
F. Home Health Aide and Homemaker Services. Either Homemaker or Home Health Aide Services or both are covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care;
G. Palliative drugs prescribed for pain control and symptom management of the terminal illness. Certain drugs are limited to a maximum 30-day supply in any 30-day period;
H. Durable Medical Equipment;
I. Respite Care when necessary to relieve the Insured Person's caregivers. Respite Care is occasional short-term Inpatient care limited to no more than five consecutive days at a time;
J. Counseling Services and Bereavement Services;
K. Dietary counseling;
L. The following care during periods of crisis when the Insured Person needs continuous care to achieve palliation or management of acute medical symptoms:
1. Nursing care services on a continuous basis for as much as 24 hours a day as necessary to maintain the Insured Person at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that Inpatient Skilled Nursing Care is required at a level that cannot be provided in the home
O. Volunteer Services.

For purposes of this benefit, the following definitions apply:

Bereavement Services means those services available to the surviving family members for a period of at least one year after the death of the Insured Person. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Insured Person.

Home Health Aide Services means those services providing for the personal care of the terminally ill patient and the performance of related tasks in the patient's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home health aide services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 (Section 1725 et seq.) of the Health and Safety Code.

Homemaker Services means services that assist in the maintenance of a safe and healthy environment and services to enable the enrollee to carry out the treatment plan.

Interdisciplinary Team means the hospice care team that includes, but is not limited to, the enrollee and the patient's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction means those services provided by a licensed Physician and surgeon who is charged with the responsibility of acting as a consultant to the interdisciplinary team, a consultant to the Insured Person's attending Physician and surgeon, as requested, with regard to pain and symptom management, and liaison with Physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the medical director.

Period of Crisis means a period in which the Insured Person requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care means a written plan developed by the attending Physician and surgeon, the medical director or Physician and surgeon designee, and the interdisciplinary team that addresses the needs of an Insured Person and family admitted to the Hospice Program. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered. However, nothing in this section shall be construed to limit a health care service plan's obligations with respect to its QA program as required under Section 1300.70.

Skilled Nursing Services means nursing services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Insured Person's physician and surgeon to an Insured Person and his or her family that pertain to the palliative, supportive services required by an enrollee with a terminal illness. Skilled nursing services include, but are not limited to, Insured Person's assessment, evaluation and case management of the medical nursing needs of the Insured Person, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured Person and his or her family, and the instruction of caregivers in providing personal care to the Insured Person. Skilled nursing services shall provide for the continuity of services for the Insured Person and his or her family. Skilled nursing service shall be available on a 24-hour on-call basis.

Social Service/Counseling Services means those counseling and spiritual services that assist the Insured Person and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Terminal Disease or Terminal Illness means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

Volunteer services means those service provided by trained Hospice volunteers who have agreed to provide service under the direction of a Hospice staff member who has been designated by the Hospice to provide direction to Hospice volunteers. Hospice volunteers may be used to provide support and companionship to the Insured Person and his or her family during the remaining days of the Insured Person's life and to the surviving family following the Insured Person's death.

25. PREVENTIVE CARE SERVICES

Benefits are payable for the following preventive care services without regard to any Cost-Sharing requirements such as Deductible, Copay or Coinsurance requirements that would otherwise apply. The following Preventive Care Services must be received from an In-Network Provider or the Out of Network Deductible will apply.

A. Evidenced-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. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention will be considered the most current other than those issued in or around November 2009. The American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.;

B. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved;
C. Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service.
D. Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan.
E. With respect to Insured Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; the American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children. and
F. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (A) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including:

1) Well-woman preventive care visits for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception and the full course of preventive prenatal care office visits are covered without Cost Sharing when delivered by an In-Network Provider.
2) One screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes.
3) High-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years.
4) One counseling session per Calendar Year for counseling on sexually transmitted infections for all sexually active women.
5) One counseling session and screening per Calendar Year for human immune-deficiency virus infection for all sexually active women.
6) All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and contraceptive counseling for all female Insured Persons with reproductive capacity and follow-up services including but not limited to, management of side effects of contraceptives, counseling for continued adherence, and device insertion and removal.. Benefits are payable for all FDA-approved contraceptive Drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the insured's provider, without Cost-Sharing. If the FDA has approved one or more Generic therapeutic equivalents of a contraceptive Drug, device, or product, then only Generic contraceptive Drugs, devices, and other products are covered under the Preventive Care Benefit without cost sharing and Brand Preferred and Brand Non-Preferred contraceptive Drugs, devices, and other products are covered under the Prescription Drugs and Medicines Benefit and are subject to Cost-Sharing. With respect to a female Insured Person for whom a Generic contraceptive Drug or device may be inappropriate, as determined by the Insured Person's Physician, We will waive the otherwise applicable Cost-Sharing for the Brand Preferred or Brand Non-Preferred contraceptive Drug or device. Generic Drugs, Brand Preferred Drugs and Brand Non-Preferred Drugs are defined in the Prescription Drugs and Medicines Benefit. Benefits include Over-the-counter FDA approved contraceptive methods for women as prescribed by a health care Provider, and procedures to implant and remove internally implanted time-release contraceptives (implants) and intrauterine devices (IUDs)
7) One screening and counseling for interpersonal and domestic violence per Calendar Year.
8) Breastfeeding support, supplies and counseling in conjunction with each birth: Benefits are payable for comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period. Coverage includes the costs or renting or purchase of one breast pump per Pregnancy for the duration of the breast feeding.

The following are examples of Covered Preventive Care Services:
A. Eye exams for refraction and preventive vision screenings;
B. Family planning counseling and programs;
C. Flexible sigmoidoscopies and screening colonoscopies;
D. Tobacco cessation programs
E. Hearing exams and screenings;
F. Immunizations (including the vaccine);
G. Preventive counseling, such as STD prevention counseling;
H. Routine preventive imaging services, such as the following:

1) Abdominal aortic aneurysm screening;
2) Bone density scans;
3) Mammograms.

I. Routine physical maintenance exams;
J. Routine preventive retinal photography screenings;
K. Scheduled prenatal care exams and first postpartum follow-up consultation and exam;
L. Tuberculosis tests;
M. Well-child preventive care exams (0–23 months);
N. The following routine preventive laboratory tests and screenings:
1) Cervical cancer screenings;
2) Cholesterol tests (lipid panel and profile);
3) Diabetes screening (fasting blood glucose tests);
4) Fecal occult blood tests;
5) HIV tests;
6) Prostate specific antigen tests;
7) Certain sexually transmitted disease (STD) tests.

Preventive Care Services also includes all generally medically accepted cancer screening tests including but not limited to:

A. Annual cervical pap smear;
B. Cytology examinations on a reasonable periodic basis;
C. Mammography;
D. Prostate Cancer Screening
Benefits are payable for a medically recognized diagnostic examination for the detection of prostate cancer. Coverage includes:
1) A physical examination for the detection of prostate cancer; and
2) A prostate-specific antigen test used for the detection of prostate cancer for each male who:
a. Is at least 50 years of age and is asymptomatic; or
b. Is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

E. Colorectal Cancer Screening
Benefits are payable for medically recognized diagnostic examinations and laboratory tests for colorectal cancer for Insured Persons who are 50 years of age or older, or less than fifty (50) years of age and at high risk for colorectal cancer according to the most current American Cancer Society colorectal cancer screening guidelines for the detection of colorectal cancer.

26. PRESCRIPTION DRUGS AND MEDICINES

All Medically Necessary Outpatient Prescription Drugs are Covered Charges including disposable devices that are Medically Necessary for the administration of a covered Outpatient Prescription Drug. Benefits are payable for prescription drugs and medicines including Injectable and Specialty Medications which are in excess of the Copay per prescription order specified in the Schedule of Benefits.

The following are examples of covered Outpatient drugs, supplies, and supplements:

A. Drugs for which a prescription is required by law.
B. Disposable needles and syringes needed for injecting covered drugs and supplements;
C. Inhaler spacers needed to inhale covered drugs;
D. Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria);
E. Cancer chemotherapy drugs and certain critical adjuncts following a diagnosis of cancer;
F. Certain drugs for the treatment of Life-Threatening ventricular arrhythmias;
G. Drugs for the treatment of tuberculosis;
H. Elemental dietary enteral formula when used as a primary therapy for regional enteritis;
I. Hematopoietic agents for dialysis and for the treatment of anemia in chronic renal insufficiency;
J. Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion;
K. In connection with a transplant, immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus;

L. Low molecular weight heparin for acute therapy for Life-Threatening thrombotic disorders; and
M. Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end-stage renal disease.
N. Orally administered anticancer prescription drugs. A Copayment of $200 applies to a 30 day supply of oral chemotherapy medication if the cost-sharing exceeds $200

Outpatient Covered Prescription Drug Charges
Outpatient covered Prescription Drug charges are those incurred by an Insured Person for Federal Drug Administration (FDA) approved drugs which are: lawfully obtainable only upon the written prescription of a Physician, and obtained from a licensed pharmacist.

This benefit includes inhaler spacers and the following equipment and supplies when Medically Necessary for the management and treatment of pediatric asthma:
A. Nebulizers, including face masks and tubing.
B. Peak flow meters.

We will not limit or exclude coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
A. The Drug is approved by the FDA.
B. 1) The Drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or
2) The Drug is prescribed by a participating licensed health care professional for the treatment of a Chronic and Seriously Debilitating Condition, the drug is medically necessary to treat that condition,.
C. The Drug has been recognized for treatment of that condition by any of the following:
1) The American Hospital Formulary Service's Drug Information.
2) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
a. The Elsevier Gold Standard's Clinical Pharmacology.
b. The National Comprehensive Cancer Network Drug and Biologics Compendium.
c. The Thomson Micromedex DrugDex.
3) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

This Benefit also includes Medically Necessary services associated with the administration of a drug, subject to the conditions of the Policy.

For purposes of this benefit, the following definitions apply:

Life-threatening means either or both of the following:
A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Chronic and Seriously Debilitating means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Drug Categories
Outpatient Prescription Drugs are separated into four categories:
A. **Generic Drugs (Tier 1).** These are Prescription Drugs that are chemically and therapeutically equivalent to brand name Prescription Drugs in the same class but are not protected by a patent. The FDA approves generic Prescription Drug as bioequivalent - meaning they perform in Your body the same as a brand preferred and/or brand non-preferred Prescription Drug. These Prescription Drugs are generally less costly than their brand-name counterparts.
B. **Brand Preferred Drugs (Tier 2).** Brand-name Prescription Drugs that have been determined to be superior or equal to brand non-Preferred Prescription Drugs, but are more cost effective.
C. **Brand Non-Preferred Drugs (Tier 3).** These brand-name Prescription Drugs have a more cost-effective therapeutic alternative.

D. **Injectable and Specialty Medications (Tier 4).** To obtain Injectable and Specialty Medications, the Insured Person must contact a pharmacy Provider designated by Us as a specialty pharmacy Provider. If the Insured Person obtains the benefit from a Provider other than the specialty pharmacy Provider designated by Us, the Insured Person must pay for the services and will be reimbursed at the Negotiated Rate then in force for the specialty Provider. Benefits for Injectable and Specialty Medications are paid under the Prescription Drugs and Medicines Benefit and are subject to the Deductible, Coinsurance Percentage, and Out-of-Pocket Maximum shown on the Schedule of Benefits.

Refer to Your Schedule of Benefits for the benefit level of each category.

If the pharmacy's retail price for an Outpatient Prescription Drug is less than the applicable copayment amount, the Insured Person will not be required to pay any more than the retail price.

We will cover a single-tablet drug regimen that is as effective as a multi-tablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multi-tablet regimen is clinically equally or more effective and more likely to result in adherence to a drug regimen

Benefits are payable for all FDA-approved contraceptive Drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the insured's provider, without Cost-Sharing. If the FDA has approved one or more Generic therapeutic equivalents of a contraceptive Drug, device, or product, then only Generic contraceptive Drugs, devices, and other products are covered under the Preventive Care Benefit without cost sharing and Brand Preferred and Brand Non-Preferred contraceptive Drugs, devices, and other products are covered under the Prescription Drugs and Medicines Benefit and are subject to Cost-Sharing. With respect to a female Insured Person for whom a Generic Drug or device may be inappropriate, as determined by the Insured Person's Physician, We will waive the otherwise applicable Cost-Sharing for the Brand Preferred or Brand Non-Preferred contraceptive Drug or device. There will be no restrictions or delays for coverage for contraceptives except for contraceptives that are not on the formulary or are covered subject to cost sharing because therapeutic equivalents have been approved by the FDA.

If the Covered Person's Physician recommends a particular service or FDA approved item based on a determination of Medical Necessity with respect to that Covered Person, We will cover that service or item without Cost-Sharing. We will defer to the determination of the attending Physician. Medical Necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending Physician.

The formulary can be found on the website [**https://content.meritain.com/DownloadFile.aspx?docid=ADA7D78C-8D6D-420F-AF82-EC13AF6B5D43**][18].

All Prior Authorization requests should be made by using the Prescription Drug Prior Authorization Form.

Prescription Drug Prior Authorization Request

You or Your Physician can submit a request to Us for prior authorization to cover non formulary Drugs. This is called a request for prior authorization. In the event that the prior authorization is approved, We must treat the excepted drug(s) as an essential health benefit.

Standard Exception Request

Your Physician may call to request a standard review of a decision that a Drug is not covered by the Plan. The Physician can call the customer service number on the back of the Insured Person's ID card. The Physician should make this request before writing the prescription.

We must make a determination on the standard exception request and notify You or the prescribing Physician of its coverage determination no later than 72 hours following receipt of the request.

When We grant a standard exception request, We will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited Exception Request

You or Your Physician can request an expedited review based on exigent circumstances. Exigent circumstances exist when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are undergoing a current course of treatment using a non-formulary drug.

We must make the coverage determination on an expedited review request based on exigent circumstances and notify You and the prescribing Physician of its coverage determination no later than 24 hours following receipt of the request.

When We grant an exception based on exigent circumstances, We will provide coverage of the non-formulary drug for the duration of the exigency.

External Prescription Request Review

If We deny a request for a standard exception or for an expedited exception, You or the prescribing Physician can request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

The independent review organization must make its determination on the external exception request and notify You and the prescribing Physician of its coverage determination no later than 72 hours following its receipt of a standard exception request, and no later than 24 hours following its receipt of an expedited exception request. If the independent review organization grants an external exception review of a standard exception request, We must provide coverage of the non-formulary drug for the duration of the prescription. If the independent review organization grants an external exception review of an expedited exception request, We must provide coverage of the non-formulary drug for the duration of the exigency

Pharmacy Benefit Manager

A Pharmacy Benefit Manager (PBM) administers Your Outpatient Prescription Drug Benefit. The PBM has contracted with a network of In-Network pharmacies to dispense Outpatient Prescription Drugs at contracted rates.

A. If the dispensing Pharmacy is a member of the PBM, the Insured Person must show his or her Prescription Drug card to the Pharmacist (or where applicable, to the Physician) and pay the amount specified in the Schedule of Benefits based on the type of Outpatient Prescription Drug and the level of coverage available as specified in the Schedule of Benefits. The Pharmacy will then bill the PBM for the balance of the charges.
B. If the dispensing Pharmacy is not a member of the PBM, or if the Insured Person elects not to use his or her Prescription Drug card, the Insured must complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the PBM, which will then reimburse the Insured Person as though the prescription card had been utilized.

In-Network Pharmacies provide the PBM with negotiated discounted rates. If the dispensing pharmacy is not a member of the PBM, or if the Insured Person does not use his or her Prescription Drug card, the Insured Person will be reimbursed on the same basis as would have been paid by the PBM to an In-Network Pharmacy.

An Insured Person is responsible for the payment of the following if the Prescription Drug was dispensed by an Out-of-Network pharmacy or where the Prescription Drug is dispensed at an In-Network Pharmacy, but the Insured Person elects a brand-name Prescription Drug when an equivalent generic Prescription Drug is available:

A. Any Copay, Deductible and Coinsurance as specified in the Schedule of Benefits;
B. The additional amount over what We would have paid a participating dispensing pharmacy;
C. Prescription Drugs which are dispensed in excess of the dispensing limitation.

Dispensing Limitation

In order for expenses for Outpatient Prescription Drug to be considered Covered Charges , the dispensing Pharmacy may not dispense more than the following at one time:

A. For other than prescription mail orders - See Your Schedule of Benefits regarding supply amounts; or
B. For prescription mail orders - . See Your Schedule of Benefits regarding supply amounts.

Excluded Drugs

A. Over-the-Counter Drugs and Products, except diabetes drugs and drugs and products covered as Preventive Care in this Part 5 - Covered Charges;
B. Fertility Agents;
C. Vitamins (other than pre-natal);
D. Hair loss medications, e.g. Rogaine, Monoxidil;
E. Investigational use or Experimental drugs;
F. Drugs covered under Workers' Compensation;
G. Weight loss Drugs; except when a weight loss Drug is Medically Necessary for the treatment of morbid obesity;
H. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;

I. Homeopathic medications;
J. Any drugs purchased outside the United States of America;
K. Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging;
L. Compounded products unless one of the ingredients requires a prescription by law; or
M. Drugs prescribed to shorten the duration of the common cold.

All Outpatient Prescription Drugs listed above may be covered if Medically Necessary.

27. ACUPUNCTURE AND ACUPRESSURE
Benefits are payable for Medically Necessary acupuncture and acupressure.

28. DURABLE MEDICAL EQUIPMENT
Benefits are payable as indicated on the Schedule of Benefits for the rental or purchase of Durable Medical Equipment (DME. A Physician must prescribe the Durable Medical Equipment for an Insured Person and submit a written statement of Medical Necessity. We will pay for the replacement of Durable Medical Equipment due to normal wear and tear.

If the DME device is covered, the supplies associated with the equipment will also be covered.
The following are covered:
A. Diabetic Shoes and Inserts
B. Glucose Monitors, Infusion Pumps, and Related Supplies.
C. Respiratory Drug Delivery Devices.
D. Tracheostomy Equipment.
E. Canes and Crutches.
F. Dry pressure pad for a mattress.
G. Cervical traction equipment (over door).
H. Osteogenesis Stimulation Devices.
I. Enteral and Parenteral Nutrition.
J. Hospital grade breast pump and double breast pump kit.
K. IV Pole.
L. Phototherapy (bilirubin) light with photometer.
M. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.
N. Non-segmental home model pneumatic compressor for the lower extremities.
O. Prosthetic Devices Incident to Mastectomy
P. Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired.

29. PHENYLKETONURIA (PKU) TESTING AND TREATMENT
Benefits are payable for special dietary formulas and special food products for the therapeutic treatment of an Insured Person for phenylketonuria provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria.

30. COMPREHENSIVE PREVENTIVE CARE OF CHILDREN
Benefits are payable for comprehensive preventive care of Covered Dependent children 18 years of age and younger for: (a) periodic health evaluations; (b) immunizations; and (c) laboratory services in connection with periodic health evaluations.

31. ANTIBIOTIC THERAPY
Benefits are payable for antibiotic therapy administered intravenously in a home-health setting.

32. CLINICAL TRIALS
Benefits are payable for Routine Patient Costs incurred by Qualified Individuals who participate in an Approved Clinical Trial.

For the purpose of this Benefit, the following definitions apply:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

A. Federally funded trials
The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1) The National Institutes of Health.
2) The Centers for Disease Control and Prevention.
3) The Agency for Health Care Research and Quality.
4) The Centers for Medicare & Medicaid Services.
5) A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7) Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   a. The Department of Veterans Affairs.
   b. The Department of Defense.
   c. The Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means an Insured Person who meets the following conditions:

A. The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.
B. Either:
   1) The referring health care Provider has concluded that the Insured Person's participation in the Clinical Trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph A above; or
   2) The Insured Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph A above.

Routine Patient Costs means all items and services that are typically covered by the Policy for a Qualified Individual who is not enrolled in a Clinical Trial. Routine patient costs do not include:

A. The investigational item, device, or service, itself;
B. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

33. AIDS VACCINE
Benefits are payable for a vaccine for AIDS that is approved by the federal FDA and that is recommended by the United States Public Health Service.

34. HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING
Benefits are payable for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

35. TELEMEDICINE
Benefits are payable for telemedicine.

For purposes of this benefit, the following definition applies:
Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a Physician and a Insured Person constitutes Telemedicine. For the purposes of this Definition, interactive means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

36. SPECIAL FOOTWEAR
Benefits are payable for special footwear as needed by Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or development disability.

37. PRENATAL DIAGNOSIS OF GENETIC DISORDERS OF THE FETUS
Benefits are payable for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures.

38. LEAD SCREENING
Benefits are payable for the screening of Dependent children who are Insured Persons to determine the lead level contained in the blood.

39. SURGICAL SERVICES DIRECTLY AFFECTING THE UPPER OR LOWER JAWBONE
Benefits are payable for surgical services directly affecting the upper or lower jawbone, or associated bone joints of an Insured Person. This benefit does not include the provision of dental services.

40. BEHAVORIAL HEALTH TREATMENT
Benefits are payable for Behavioral Health treatment for pervasive developmental disorder or autism.

For the purposes of this benefit, the following definition applies:
Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an Insured Person with pervasive developmental disorder or autism, and that meet all of the following criteria:

A. The treatment is prescribed by a licensed Physician and surgeon, or is developed by a licensed psychologist.
B. The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
    1) A qualified autism service provider;
    2) A qualified autism service professional supervised and employed by a qualified autism service provider;
    3) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
C. The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific Insured Person being treated. The treatment plan must be reviewed no less than once every six (6) months by the qualified autism service provider and modified whenever appropriate.
D. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participation in the treatment program. The treatment plan must be made available to Us upon request.

41. SECOND OPINIONS
Benefits are payable for a second opinion provided to You when Medically Necessary by an appropriately qualified medical professional. This is a Physician who is acting within his or her scope of practice and who possesses a clinical background related to the condition associated with the request for a second medical opinion.

You can either ask your Physician to help you arrange for a second medical opinion, or you can make an appointment with another Physician. If We determine that there isn't a Physician who is an appropriately qualified medical professional for your condition, We will authorize a referral to an Out of Network Physician for a Medically Necessary second opinion.

42. BARIATRIC SURGERY
Benefits are payable for Hospital Inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if a Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary.

If an Insured Person lives 50 miles or more from the facility to which the Insured Person is referred by an In-Network Physician, for a covered bariatric surgery, We will reimburse You for certain travel and lodging expenses if You receive prior written authorization from Us and send Us adequate documentation including receipts. We will reimburse authorized and documented travel and lodging expenses for the following as shown in the Schedule of Benefits:

A. Transportation for the Insured Person to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which We provided reimbursement under any other Policy of Insurance offered by Your Employer.
B. Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which We provided reimbursement under any other Policy of Insurance offered by Your Employer.
C. One hotel room, double-occupancy, for You and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which We provided reimbursement under any other Policy of Insurance offered by Your Employer.
D. Hotel accommodations for one companion not to exceed $100 per day for the duration of Your surgery stay, up to four days, including any hotel accommodations for which We provided reimbursement under any other Policy of Insurance of coverage offered by Your Employer.

43. DENTAL SERVICES FOR RADIATION TREATMENT

Benefits are payable for dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck.

44. DENTAL AND ORTHODONTIC SERVICES FOR CLEFT PALATE

Benefits are payable for dental extractions, and other dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if the Services are an integral part of a reconstructive surgery for cleft palate that We are covering.

45. DIALYSIS CARE

Benefits are payable for acute and chronic dialysis Services.

After an Insured Person receives appropriate training at a dialysis facility, We also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis with no Cost Sharing. Coverage is limited to the standard item of equipment or supplies that adequately meets the Insured Person's medical needs. We decide whether to rent or purchase the equipment and supplies, and We select the vendor. You must return the equipment and any unused supplies to Us or pay Us the fair market price of the equipment and any unused supply when We are no longer covering them.

46. OSTOMY, UROLOGICAL AND INCONTINENCE SUPPLIES

Benefits are payable for ostomy, urological and incontinence supplies. We may select the vendor and coverage is limited to the standard supply that adequately meets the Insured Person's medical needs.

47. VISION SERVICES

Benefits are payable for Insured Persons for eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses. We cover special contact lenses for anirida when prescribed by a Physician limited to a maximum of two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period.

48. INFERTILITY

Benefits are payable as shown the Schedule of Benefits for Infertility services including consultations, examinations, diagnostic surgical services related to Hospitalizations or facilities, treatment and drug therapy for involuntary infertility. The level of benefits for all services, including the diagnostic work-up and testing to establish a cause of Infertility are specified in the Schedule of Benefits when obtained with prior authorization.

A. Covered Charges include artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime; AND **ONE** Gamete intrafallopian transfer (GIFT) **OR** IVF per lifetime. (Lifetime is defined to include services provided under this Policy or any other health insurance.) Medications for the treatment of Infertility require copay equal to 50% of the contracted prescription cost. Genetic testing and counseling are Covered Charges when medically indicated and are not subject to the Infertility Copayments.
B. No benefits shall be payable under the Policy for any expenses caused by, incurred for, or resulting from:
    1) Services and supplies to reverse voluntary, surgically induced infertility.
    2) Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy.
    3) Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT).
    4) ICSI, Intracytoplasmic Sperm Injection.
    5) Ova Sticks (a self-test for infertility).

6) Ovum Transfer/Transplants or Uterine Lavage as part of infertility diagnosis or treatment.
7) Sperm Donor, including the actual collection of the sperm.
8) Sperm Storage. Storage is not for the treatment of a disease or medical condition and is not Medically Necessary.
9) Infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts.
10) Artificial insemination/donor sperm in lieu of a partner is not covered.
11) Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
12) Experimental diagnostic studies, procedures or drugs used to treat or determine the cause of Infertility.
13) Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos.
14) Inoculation of women with partner's white cells (considered Experimental).

For purposes of this Benefit, the following definition applies:
Infertility means a condition recognized by a Physician as a cause of, or the inability to conceive a Pregnancy or to carry a Pregnancy to a live birth after one year or more of regular sexual relations without contraception.

49. NICOTINE USE
Benefits are payable for nicotine use treatment when provided in a facility licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250) of Division 2 of the California Health and Safety Code.

50. WEIGHT MANAGEMENT PROGRAMS
Benefits are payable for weight management and weight reduction programs undertaken by an Insured Person that are designed to keep body weight at a healthy level and promote regular exercise and a healthy diet.

A weight management or weight reduction program requires Pre-authorization pursuant to Part 3 – Medical Management, Pre-Authorization Program.

This Benefit does not include wiring of the teeth; fitness center, gym or health club membership fees or dues.

This Benefit also does not include the following related to weight management or weight loss: Books, DVDs, CDs, cremes, lotions, pills, rings and earrings, body wraps, body belts and other such materials, personal coaches, weight loss groups, and food products and supplements.

51. HEALTH EDUCATION PROGRAMS

Benefit are payable for health education programs for tobacco cessation, stress management, and chronic conditions including diabetes and asthma.

52. TERMINATION OF PREGNANCY

Benefits are payable for therapeutic and elective abortions.

53. MANIPULATIVE SERVICES

Benefits are payable up to the maximum number of visits per Year shown in the Schedule of Benefits for spinal manipulation, manual or electrical muscle stimulation, other manipulative or ultrasound therapy when performed by a health care Provider, and any other non-surgical treatment of the spine.

54. **SPECIAL CONTACT LENSES FOR ANIRIDIA (ADULTS)**
Benefits are payable for Medically Necessary special contact lenses for aniridia when Preauthorization is obtained for Insured Persons over the age of 19.

55. TRIAGE OR SCREENING SERVICES
Benefits are payable for the assessment of an Insured Person's health concerns and symptoms via communication, with a Physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an Insured Person who may need care, for the purpose of determining the urgency of the Insured Person's need for care. The contact number is [1-800-XXX-XXXX][19]. This will get You in touch with the qualified health professional. Triage or screening services are covered 24 hours a day, 7 days a week.

56. OSTEOPOROSIS
Benefits are payable for services related to diagnosis, treatment, and appropriate management of osteoporosis, including bone mass measurement technologies as deemed medically appropriate.

57. TRANSGENDER SURGERY
Benefits are payable for transgender surgical services(genital or mastectomy).

58. MALE STERLIZATION PROCEDURES
Benefits are payable for male sterilization procedures if the procedure is provided in an outpatient or Ambulatory Surgical Center or in a Hospital operating room.

PART 6 – PEDIATRIC DENTAL AND VISION CARE COVERED CHARGES

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental Provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, You may call member services at [insert appropriate telephone number][20] or your insurance broker. To fully understand Your coverage, You may wish to carefully review this Certificate of Insurance .

Notwithstanding any other provisions of the Policy, Covered Charges under this Part are not covered under any other provision of the Policy. An amount in excess of the maximum amount provided under this Part, if any, are not covered under any other provision in the Policy.

All terms used in this Part have the same meaning given to them in this Certificate, unless otherwise specifically defined in this Part. Refer to the Pediatric Dental Care Limitations and Exclusions and the Pediatric Vision Care Limitations and Exclusions in this Part and the General Exclusions and Limitations Part of this Certificate for Pediatric Dental Care and Pediatric Vision Care expenses not covered by the Policy. All other terms and provisions of the Policy are applicable to expenses covered for Pediatric Dental Care and Pediatric Vision Care.

Covered Charges for Pediatric Dental Care and Pediatric Vision Care apply toward the Deductible and Out-of-Pocket Maximum amount.

Pediatric Dental Care Covered Charges

We will pay for Covered Charges incurred by an Insured Person for pediatric dental services including emergency and urgent dental care. Pediatric dental services include the following as categorized below.

Diagnostic and Preventive Services

Examinations/Evaluations
D0120 – periodic oral evaluation (once every six months per provider)
D0140 – limited oral evaluation – problem focused
D0145 – Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 – comprehensive oral evaluation
D0160 – detailed and extensive oral evaluation (problem focused by report)
D0170 – reevaluation limited, problem focused (established patient; not post-operative visit.)
D0180 – Oral examination, comprehensive periodontal evaluation
D0190 – Screening of a patient

Cleanings (Prophylaxes) [(2)]
D1120 – prophylaxis – child

[(2)] Cleanings are Limited to One (1) Every Six (6) Months – additional cleanings when Medically Necessary is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

Fluoride Treatment [(3)]
D1208 – topical application of fluoride (prophylaxis not included)
D1206 – topical fluoride varnish

(3) Fluoride Treatment is Limited to Two (2) Every Twelve (12) Months - additional treatments when Medically Necessary is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

Space Maintainers
D1510 – space maintainer – fixed – unilateral (once per quadrant)
D1515 – space maintainer – fixed – bilateral(once per arch)
D1520 – space maintainer – removable – unilateral (once per quadrant)
D1525 – space maintainer – removable – bilateral(once per arch)
D1550 – re-cementation of space maintainer(once per provider per quadrant or arch)
D1555 – Removal of fixed space maintainer (not by dentist who placed appliance)

Brush Biopsy
D0486 – Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report
D7288 – Brush biopsy – transepithelial sample collection

Emergency Palliative Treatment
D9110 – palliative (emergency) treatment of dental pain – minor procedure

Radiographs (X-rays)/Diagnostic Imaging/Diagnostic Casts
D0210 – intraoral-complete series (including bitewings)
D0220 – intraoral–periapical first film
D0230 – intraoral–periapical each additional film
D0240 – intraoral–occlusal film
D0250 – Extraoral – first film
D0260 – Extraoral – each additional film
D0270 – bitewing – single film
D0272 – bitewings – two films
D0273 – bitewings – three films
D0274 – bitewings – four films
D0277 – bitewing, vertical, 7 to 8 films
D0290 – Posterior – anterior or lateral skull and facial bone survey film
D0310 – Sialography
D0320 – tempomadibular joint arthrogram, including injection
D0322 – tomographic survey
D0330 – panoramic film
D0340 – cephalometric radiographic image
D0350 – oral/facial photographic images
D0502 – other oral pathology procedures by report
D0999 – Unspecified diagnostic procedure, by report

Sealants
D1351 – Sealant – per tooth – unrestored permanent molars
D1352 – preventive resin restoration in a moderate to high caries risk patient-permanent tooth

Basic Services

Minor Restorative Services (local anesthesia is considered to be part of restorative procedures)
D2140 – amalgam – one surface, primary or permanent
D2150 – amalgam – two surfaces, primary or permanent
D2160 – amalgam – three surfaces, primary or permanent
D2161 – amalgam – four or more surfaces, primary or permanent
D2330 – resin–based composite – one surface, anterior
D2331 – resin–based composite – two surfaces, anterior
D2332 – resin–based composite – three surfaces, anterior
D2335 – resin–based composite – four or more surfaces or involving incisal angle (anterior)
D2390 – Resin–based composite crown, anterior

D2391 – Resin-based composite – one surface, posterior
D2392 – resin-based composite – two surfaces, posterior
D2393 – Resin-based composite – three surfaces, posterior
D2394 – Resin-based composite – four or more surfaces, posterior
D2940 – sedative filling
D2951 – pin retention – per tooth, in addition to restoration
D2910 – recement inlay, only or partial coverage restoration
D2915 – recement cast or prefabricated post and core
D2920 – recement crown
D2929 – prefabricated porcelain/ceramic crown – primary tooth
D2980 – crown repair, by report
D2981 – inlay repair, by report
D2982 – onlay repair, by report
D2983 – veneer repair, by report
D2999 – unspecified procedure, by report

Periodontal Maintenance Services
D4910 – periodontal maintenance procedures (following active therapy).

Relines and Repairs
D5410 – adjust complete denture – maxillary
D5411 – adjust complete denture – mandibular
D5421 – adjust partial denture – maxillary
D5422 – adjust partial denture – mandibular
D5510 – repair broken complete denture base
D5520 – replace missing or broken teeth – complete denture (each tooth)
D5610 – repair resin denture base
D5620 – repair cast framework
D5630 – repair or replace broken clasp
D5640 – replace broken teeth – per tooth
D5650 – add tooth to existing partial denture
D5660 – add clasp to existing partial denture
D5670 – replace all teeth and acrylic on cast metal framework (maxillary)
D5671 – replace all teeth and acrylic on cast metal framework (mandibular)
D5710 – rebase complete maxillary denture
D5711 – rebase complete mandibular denture
D5720 – rebase maxillary partial denture
D5721 – rebase mandibular partial denture
D5730 – reline complete maxillary denture
D5731 – reline complete mandibular denture
D5740 – reline maxillary partial denture
D5741 – reline mandibular partial denture
D5750 – reline complete maxillary denture (laboratory)
D5751 – reline complete mandibular denture (laboratory)
D5760 – reline maxillary partial denture (laboratory)
D5761 – reline mandibular partial denture (laboratory)
D5850 – tissue conditioning denture (maxillary)
D5851 – tissue conditioning denture (mandibular)
D5863 – Overdenture – Complete Maxillary,
D5864 – Overdenture – Partial Maxillary,
D5865 – Overdenture – Complete Mandibular
D5866 – Overdenture – Partial Mandibular
D5899 – unspecified removable prosthodontic procedure, by report
D6930 – recement fixed partial denture
D6980 – fixed partial denture repair by report

Other Basic Services
D0460 – pulp vitality tests
D0470 – diagnostic models
D9310 – consultation (diagnostic service provided by dentist other than practitioner providing treatment)
D9220 – deep sedation/general anesthesia – first 30 minutes
D9221 – deep sedation/general anesthesia – each additional 15 minutes
D9241 – intravenous conscious sedation/analgesia – first 30 minutes
D9242 – intravenous conscious sedation/analgesia – each additional 15 minutes
D9248 – non–intravenous conscious sedation
D9920 – behavior management, by report
D9930 – treatment of complications (post–surgical) – unusual circumstances, by report

Major Services

Major Restorative Services
D2542 – onlay – metallic – two surfaces
D2543 – onlay – metallic – three surfaces
D2544 – onlay – metallic – four or more surfaces
D2642 – onlay – porcelain/ceramic – two surfaces
D2643 – onlay – porcelain/ceramic – three surfaces
D2644 – onlay – porcelain/ceramic – four or more surfaces
D2662 – onlay – resin–based composite – two surfaces
D2663 – onlay – resin–based composite – three surfaces
D2664 – onlay – resin–based composite – four or more surfaces
D2710 – crown – resin–based composite (indirect)
D2712 – crown – 3/4 resin–based composite (indirect)
D2720 – crown – resin with high noble metal
D2721 – crown – resin with predominantly base metal
D2722 – crown – resin with noble metal
D2740 – crown – porcelain/ceramic substrate
D2750 – crown – porcelain fused to high noble metal
D2751 – crown – porcelain fused to predominantly base metal
D2752 – crown – porcelain fused to noble metal
D2780 – crown – 3/4 cast high noble metal
D2781 – crown – 3/4 cast predominantly base metal
D2782 – crown – 3/4 cast noble metal
D2783 – crown – 3/4 porcelain/ceramic (This code does not include facial veneers)
D2790 – crown – full cast high noble metal
D2791 – crown – full cast predominantly base metal
D2792 – crown – full cast noble metal
D2794 – crown – titanium
D2799 – Provisional crown
D2930 – prefabricated stainless steel crown – primary tooth
D2931 – prefabricated stainless steel crown – permanent tooth
D2932 – prefabricated resin crown
D2933 – prefabricated stainless steel crown with resin window
D2934 – prefabricated esthetic coated stainless steel crown – primary tooth
D2950 – core buildup, including pins
D2952 – cast post and core in addition to crown, indirectly fabricated
D2954 – prefabricated post and core in addition to crown
D2955 – post removal (not in conjunction with endodontic therapy)
D2960 – labial veneer – (resin laminate) chairside
D2961 – labial veneer (resin laminate) – laboratory
D2962 – labial veneer (porcelain laminate) – laboratory
D2970 – temporary crown (fractured tooth)
D2971 – additional procedures to construct new crown under existing partial denture framework

Oral and Maxillofacial Surgery Services

D7111 – Extraction, coronal remnants – deciduous tooth
D7140 – extraction, erupted tooth or exposed root (elevation and/or forceps removal).
D7210 – surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 – removal of impacted tooth – soft tissue
D7230 – removal of impacted tooth – partial bony
D7240 – removal of impacted tooth – completely bony
D7241 – removal of impacted tooth – completely bony, with unusual surgical complications
D7250 – surgical removal of residual tooth roots (cutting procedure)
D7260 – oral antral fistula closure
D7261 – primary closure of a sinus perforation
D7270 – tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 – surgical access of an unerupted tooth
D7282 – Mobilization of erupted or malpositioned tooth to aid eruption
D7283 – Placement of device to facilitate eruption of impacted tooth
D7285 – biopsy of oral tissue hard(bone, tooth)
D7286 – Biopsy of soft tissue – soft
D7290 – Surgical repositioning of teeth
D7291 – Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310 – alveoloplasty in conjunction with extractions – per quadrant
D7311 – alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320 – alveoloplasty not in conjunction with extractions – per quadrant
D7321 – alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7340 – vestibuloplasty-ridge extension (secondary epithelialization)
D7350 - vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410, D7411 and D7412 – Excision of Benign Lesion,
D7413, D7414 and D7515 – Excision of Malignant Lesion
D7440-7441 – Excision of Malignant Tumor Lesion Diameter
D7450-D7451 - Removal of Benign Odontogenic Cyst or Tumor Lesion Diameter
D7460-D7461 – Removal of Benign Nonodontegenci Cyst or Tumor Lesion
D7465 – Destruction of Lesion(s) by Physical or Chemical Method, by report
D7471 – Removal of Lateral Exostosis (Maxilla or Mandible)
D7472 – Removal of Torus Palatinus
D7473 – Removal of Torus Mandibularis
D7485 – Surgical Reduction of Osseous Tuberosity
D7490 – Radical Resection of Maxilla or Mandible
D7510 – incision and drainage of abscess – intraoral soft tissue
D7511 – incision and drainage of abscess – intraoral soft tissue – complicated

D7520 – Incision and Drainage of Abscess Extraoral Soft Tissue
D7521 – Incision and Drainage of Abscess Extraoral Soft Tissue – Complicated (Includes Drainage of Multiple Facial Spaces)
D7530 – Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue
D7540 – Removal of Reaction Producing Foreign Bodies, Musculoskeletal System
D7550 – Partial Ostectomy/Sequestrectomy for Removal of Non-Vital Bone
D7560 – Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
D7610 – Maxilla Open Reduction (Teeth Immobilized, if present)
D7620 – Maxilla Closed Reduction (Teeth Immobilized, if present)
D7630 – Mandible Open Reduction (Teeth Immobilized, if present)
D7640 – Mandible Closed Reduction (Teeth Immobilized, if present)
D7650 – Malar and/or Zygomatic Arch Open Reduction
D7660 – Malar and/or Zygomatic Arch Closed Reduction
D7670 – Alveolus Closed Reduction, May Include Stabilization of Teeth

D7671 – Alveolus Open Reduction, May Include Stabilization of Teeth
D7680 – Facial Bones Complicated Reduction with Fixation and Multiple Surgical Approaches
D7710 – Maxilla Open Reduction
D7720 – Maxilla Closed Reduction
D7730 – Mandible Open Reduction
D7740 – Mandible Closed Reduction
D7750 – Malar and/or Zygomatic Arch Open Reduction
D7760 – Malar and/or Zygomatic Arch Closed Reduction
D7770 – Alveolus Open Reduction Stabilization of Teeth
D7771 – Alveolus Closed Reduction Stabilization of Teeth
D7780 – Facial Bones Complicated Reduction with Fixation and Multiple Surgical Approaches
D7810 – Open Reduction of Dislocation
D7820 – Closed Reduction of Dislocation
D7830 – Manipulation under Anesthesia
D7840 – Condylectomy
D7850 – Surgical Discectomy, With/Without Implant
D7852 – Disc Repair
D7854 – Synovectomy
D7856 – Myotomy
D7858 – Joint Reconstruction
D7860 – Arthrotomy
D7865 – Arthroplasty
D7870 – Arthrocentesis
D7871 – Non-Arthroscopic Lysis and Lavage
D7872 – Arthroscopy Diagnosis With or Without Biopsy
D7873 – Arthroscopy Surgical: Lavage and Lysis of Adhesions
D7874 – Arthroscopy Surgical: Disc Repositioning and Stabilization
D7875 – Arthroscopy Surgical: Synovectomy
D7876 – Arthroscopy Surgical: Discectomy
D7877 – Arthroscopy Surgical: Debridement
D7880 – Occlusal Orthotic Device, by Report
D7899 – Unspecified TMD Therapy, by Report
D7910 – suture of recent small wounds up to 5 cm
D7911 – complicated suture – up to 5 cm
D7912 – Complicated Suture Greater Than 5 Cm
D7920 – Skin Graft (Identify Defect Covered, Location and Type of Graft)
D7940 – Osteoplasty for Orthognathic Deformities
D7941 – Osteotomy Mandibular Rami
D7943 – Osteotomy Mandibular Rami with Bone Graft; Includes Obtaining the Graft
D7944 – Osteotomy Segmented or Subapical
D7945 – Osteotomy Body of Mandible
D7946 – Lefort I (Maxilla Total)
D7947 – Lefort I (Maxilla Segmented)
D7948 – Lefort II or Lefort III (Osteoplasty of Facial Bones For Midface Hypoplasia or Retrusion) Without Bone Graft
D7949 – Lefort II or Lefort III With Bone Graft
D7950 – Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial Bones Autogenous or Nonautogenous, by Report
D7951 – Sinus Augmentation With Bone or Bone Substitutes Via A Lateral Open Approach
D7952 – Sinus Augmentation With Bone or Bone Substitute Via A Vertical Approach
D7955 – Repair of Maxillofacial Soft and/or Hard Tissue Defect
D7960 – Frenulectomy (frenectomy or frenotomy) – separate procedure
D7963 – Frenuloplasty
D7970 – Excision of hyperplastic tissue – per arch
D7971 – excision of pericoronal gingiva
D7972 – Surgical reduction of fibrous tuberosity
D7980 – Sialolithotomy
D7981 – Excision of Salivary Gland, by report

D7982 – Sialodochoplasty
D7983 – Closure of Salivary Fistula
D7990 – Emergency Tracheotomy
D7991 – Coronoidectomy
D7995 – Synthetic Graft Mandible or Facial Bones, By Report
D7997 – Appliance Removal (Not by Dentist who placed appliance), includes Removal of Arch Bar
D7999 – Unspecified oral surgery procedure, by report

Endodontic Services
D3220 – therapeutic pulpotomy (excluding final restoration)
D3221 – Pulpal debridement, primary or permanent teeth
D3222 – Partial Pulpotomy for Apexogenesis – permanent tooth with incomplete root development.
D3230 – pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
D3240 – pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D3310 – anterior (excluding final restoration)
D3320 – bicuspid (excluding final restoration)
D3330 – molar (excluding final restoration)
D3331 – Treatment of root canal obstruction; non–surgical access
D3332 – Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3333 – Internal root repair of perforation defects
D3346 – retreatment of previous root canal therapy – anterior
D3347 – retreatment of previous root canal therapy – bicuspid
D3348 – retreatment of previous root canal therapy – molar
D3351 – apexification/recalcification – initial visit (apical closure/calcific repair or perforations, root resorptions)
D3352 – apexification/recalcification – interim visit (apical closure/calcific repair or perforations, root resorptions)
D3353 – apexification/recalcification – final visit (includes completed root canal therapy – apical closure/ calcific repair or perforations, root resorptions, etc)
D3410 – apicoectomy/periradicalar surgery – anterior
D3421 – apicoectomy/periradicalar surgery – bicuspid (first root)
D3425 – apicoectomy/periradicalar surgery – molar (first root)
D3426 – apicoectomy/periradicalar surgery – (each additional root)
D3430 – retrograde filling– per root
D3450 – root amputation – per root
D3920 – hemisection (including any root removal), not including root canal therapy
D3999 – Unspecified endodontic procedure, by report

Periodontic Services
D4210 – gingivectomy or gingivoplasty – four or more teeth
D4240 – gingival flap procedure, including root planning – four or more teeth
D4211 – gingivectomy or gingivoplasty – one to three teeth
D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth or bounded teeth spaces per quadrant
D4245 – Apically positioned flap
D4249 – clinical crown lengthening – hard tissue
D4260 – osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces, per quadrant
D4261 – osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant
D4320 – Provisional splinting – intracoronal
D4321 – Provisional splinting – extracoronal
D4341 – periodontal scaling and root planning, four or more teeth per quadrant
D4342 – periodontal scaling and root planning, one to three teeth, per quadrant
D4355 – full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4920 – Unscheduled dressing change (by someone other than treating dentist)
D4999 – Unspecified periodontal procedure, by report

Prosthodontic Services (Dentures are Limited to Once per Arch Every 5 Years)
D5110 – complete denture – maxillary
D5120 – complete denture – mandibular
D5130 – immediate denture – maxillary
D5140 – immediate denture – mandibular
D5211 – maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 – mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 – maxillary partial denture – cast metal framework– resin denture base (including any conventional clasps, rests and teeth)
D5214 – mandibular partial denture – cast metal framework– resin denture base (including any conventional clasps, rests and teeth)
D5225 – Maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5226 – Mandibular partial denture – flexible base (including any clasps, rests and teeth)
D5281 – removable unilateral partial denture – one piece cast metal (including clasps and teeth)
D5820 – interim partial denture (maxillary)
D5821 – interim partial denture (mandibular)
D6210 – pontic – cast high noble metal
D6211 – pontic – cast predominantly base metal
D6212 – pontic – cast noble metal
D6214 – pontic – titanium
D6240 – pontic – porcelain fused to high noble metal
D6241 – pontic – porcelain fused to predominantly base metal
D6242 – pontic – porcelain fused to noble metal
D6245 – pontic – porcelain/ceramic
D6250 – pontic – resin with high noble metal
D6251 – pontic – resin with predominantly base metal
D6252 – pontic – resin with noble metal
D6545 – retainer – cast metal for resin bonded fixed prosthesis
D6602 – inlay – cast high noble metal, two surfaces
D6603 – inlay – cast high noble metal, three or more surfaces
D6604 – inlay – cast predominantly base metal, two surfaces
D6605 – inlay – cast predominantly base, three or more surfaces
D6606 – inlay – cast noble metal, two surfaces
D6607 – inlay – cast noble metal, three or more surfaces
D6624 – inlay – titanium
D6610 – onlay – cast high noble metal, two surfaces
D6611 – onlay – cast high noble metal, three or more surfaces
D6612 – onlay – cast predominantly base metal, two surfaces
D6613 – onlay – cast predominantly base, three or more surfaces
D6614 – onlay – cast noble metal, two surfaces
D6615 – onlay – cast noble metal, three or more surfaces
D6634 – onlay – titanium
D6720 – crown – resin with high noble metal
D6721 – crown – resin with predominantly base metal
D6722 – crown – resin with noble metal
D6740 – crown porcelain/ceramic
D6750 – crown – porcelain fused to high noble metal
D6751 – crown – porcelain fused to predominantly base metal
D6752 – crown – porcelain fused to noble metal
D6780 – crown – 3/4 cast high noble metal
D6781 – crown – 3/4 cast predominantly base metal
D6782 – crown – 3/4 cast noble metal
D6783 – crown – 3/4 porcelain/ceramic
D6790 – crown – full cast high noble metal
D6791 – crown – full cast predominantly base metal
D6792 – crown – full cast noble metal
D6794 – crown – titanium

D6999 – unspecified fixed prosthodontic procedure, by report

Maxillofacial Prosthetic Procedures
D5911 - Facial Moulage (Sectional)
D5912 – Facial Moulage (Complete)
D5913 – Nasal Prosthesis
D5914 – Auricular Prosthesis
D5915 – Orbital Prosthesis
D5916 – Ocular Prosthesis
D5919 – Facial Prosthesis
D5922 – Nasal Septal Prosthesis
D5923 – Ocular Prosthesis
D5924 – Cranial Prosthesis
D5925 – Facial Augmentation Implant Prosthesis
D5926 – Nasal Prosthesis Replacement
D5927 - Auricular Prosthesis Replacement
D5928 - Orbital Prosthesis Replacement
D5929 - Facial Prosthesis Replacement
D5931 – Obturator Prosthesis Replacement
D5932 – Obturator Prosthesis Definitive
D5933 – Obturator Prosthesis Modification – twice in a 12 month period
D5934 – Mandibular Resection Prosthesis with Guide Flange
D5935 – Mandibular Resection Prosthesis without Guide Flange
D5936 – Obturator Prosthesis, interim
D5937 – Trismus Appliance (not for TMD treatment)
D5951 – Feeding Aid – under the age of 18
D5952 – Speech and Aid Prosthesis Pediatric – under the age of 18
D5954 – Palatal Augmentation Prosthesis
D5955 – Palatal Lift Prosthesis Definitive
D5958 – Palatal Lift Prosthesis, Interim
D5959 – Palatal Lifet Prothesis, Modification – twice in a 12 month period
D5960 – Speech Aid Prosthesis, Modification – twice in a 12 month period
D5982 – Surgical Stent
D5983 – Radiation Carrier
D5984 – Radiation Shield
D5985 – Radiation Cone Locator
D5986 – Fluoride Gel Carrier
D5987 – Commissure Splint
D5988 – Surgical Splint
D5991 – Topical Medicament Carrier
D5999 – Unspecified Maxillofacial Prosthesis, by report

Implant Service
D6010 – Surgical Placement of Implant Body: Endosteal Implant
D6040 – Surgical Placement: Eposteal Implant
D6050 – Surgical Placement: Transosteal Implant
D6055 – Connection Bar Implant Supported or Abutment Supported
D6056 – Prefabricated Abutment – Includes Modification and Placement
D6057 – Custom Fabricated Abutment – Includes Placement
D6058 – Abutment Supported Porcelain/Ceramic Crown
D6059 – Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)
D6060 – Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)
D6061 – Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)
D6062 – Abutment Supported Cast Metal Crown (High Noble Metal)
D6063 – Abutment Supported Cast Metal Crown (Predominately Base Metal)
D6064 – Abutment Supported Cast Metal Crown (Noble Metal)
D6065 – Implant Supported Porcelain/Ceramic Crown

D6066 – Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)
D6067 – Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)
D6068 – Abutment Supported Retainer for Porcelain/Ceramic FPD
D6069 – Abutment Supported Retainer For Porcelain Fused to Metal FPD (High Noble Metal)
D6070 – Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominately Base Metal)
D6071 – Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)
D6072 – Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)
D6073 – Abutment Supported Retainer for Cast Metal FPD (Predominately Base Metal)
D6074 – Abutment Supported Retainer for Cast Metal FPD (Noble Metal)
D6075 – Implant Supported Retainer for Ceramic FPD
D6076 – Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)
D6077 – Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal)
D6078 – Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch
D6079 – Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch
D6080 – Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis
D6090 – Repair Implant Supported Prosthesis, by Report
D6091 – Replacement of Semi-Precision or Precision Attachment (Male or Female Component) of Implant/Abutment Supported Prosthesis, per Attachment
D6092 – Recement Implant/Abutment Supported Crown
D6093 – Recement Implant/Abutment Supported Fixed Partial Denture
D6094 – Abutment Supported Crown (Titanium)
D6095 – Repair Implant Abutment, by Report
D6100 – Implant Removal, by report
D6110 – Implant/Abutment supported removable denture for edentulous arch - maxillary
D6111 – Implant/Abutment supported removable denture for edentulous arch - mandibular.
D6112 – Implant/Abutment supported removable denture for partially edentulous arch - maxillary
D6113 – Implant/Abutment supported removable denture for partially edentulous arch - mandibular
D6114 – Implant/Abutment supported fixed denture for edentulous arch - maxillary
D6115 – Implant/Abutment supported fixed denture for edentulous arch - mandibular.
D6116 – Implant/Abutment supported fixed denture for partially edentulous arch - maxillary
D6117 – Implant/Abutment supported fixed denture for partially edentulous arch – mandibular
D6194 – Abutment Supported Retainer Crown for FPD (Titanium)
D6199 – Unspecified Implant Procedure, by report

Adjunctive Service Procedures
D9120 – Fixed Partial Denture Sectioning
D9210 – Local Anesthesia Not In Conjunction With Operative or Surgical Procedures
D9211 – Regional Block Anesthesia
D9212 – Trigeminal Division Block Anesthesia
D9215 – Local Anesthesia in Conjunction With Operative or Surgical Procedures
D9230 – Inhalation of Nitrous Oxide/Anxiolysis, Analgesia
D9410 – House/Extended Care Facility Call
D9420 – Hospital or Ambulatory Surgical Center Call
D9430 – Office Visit For Observation (During Regularly Scheduled Hours) No Other Services Performed
D9440 – Office Visit After Regularly Scheduled Hours
D9610 – Therapeutic Parenteral Drug, Single Administration
D9612 – Therapeutic Parenteral Drug, Two or More Administrations, Different Medications
D9910 – Application of Desensitizing Medicament
D9950 – Occlusion Analysis Mounted Case
D9951 – Occlusal Adjustment – Limited
D9952 – Occlusal Adjustment – Complete
D9999 – Unspecified Adjunctive Procedure, By Report

Medically Necessary Orthodontia Services

Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. Covered services include the following:

D8010 – Limited orthodontic treatment of the primary dentition
D8020 – Limited orthodontic treatment of the transitional dentition
D8030 – Limited orthodontic treatment of the adolescent dentition
D8050 – Interceptive orthodontic treatment of the primary dentition
D8060 – Interceptive orthodontic treatment of the transitional dentition
D8070 – Comprehensive orthodontic treatment of the transitional dentition
D8080 – Comprehensive orthodontic treatment of the adolescent dentition
D8090 – Comprehensive orthodontic treatment of the adult dentition
D8210 – Removable appliance therapy
D8220 – Fixed appliance therapy
D8660 – Pre-orthodontic treatment visit
D8670 – Periodic orthodontic treatment visit (as part of contract)
D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8691 – Repair of orthodontic appliance
D8692 - Replacement of lost or broken retainer
D8693 – Rebonding or recementing and or repair, as required of fixed retainers
D8999 – Unspecified orthodontic procedure, by report

SUPPLEMENTAL SERVICES

"Supplemental Services are covered when: (1) A Medically Necessary dental procedure is not listed above under Pediatric Dental Care Covered Charges; (2) A Medically Necessary dental procedure is listed above but the child does not meet the above-stated criteria for that procedure (if any); or (3) The child needs a dental service more frequently than the above-stated limits for that procedure (if any)."

Excluded Services

The following dental services are excluded under the Policy:

1. Services which, in the opinion of the attending dentist, are not necessary to the Insured Person's dental health.
2. Cosmetic Dental Care.
3. General anesthesia or intravenous/conscious sedation, unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
4. Experimental or Investigational Services; We provide an external, independent review process to examine Our coverage decisions regarding excluded Experimental or Investigational services. Please refer to the Independent Medical Review Process under Part 13 for more information.5. Services which were provided without cost to the Insured Person by the State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind except as provided under PART 5 – COVERED CHARGES.
7. Loss or theft of dentures or bridgework.
8. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Insured Person became eligible for such services.
9. Malignancies except as provided under PART 5 – COVERED CHARGES.
10. Dispensing of drugs not normally supplied in a dental office except as provided under PART 5 – COVERED CHARGES.
11. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Insured Person except as provided under Part 5 – Covered Charges.
12. The cost of precious metals used in any form of dental benefits.
13. The surgical removal of implants except as provided under PART 5 – COVERED CHARGES.
14. Services of a pedodontist/pediatric dentist for an Insured Person, except when the Insured Person is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her panel Provider is a pedodontist/pediatric dentist.
15. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. We will provide coverage for the Services at the time of need, and the Employee and Insured Person shall cooperate to assure that We are reimbursed for such benefits.

For the purposes of this Part only, the following definitions apply:

Cosmetic Dental Care means services that are primarily for the purpose of improving appearance including but not limited to:

1. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid; and
2. Characterizations and personalization of prosthetic devices.

Emergency means a dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following: Placing the Insured Person's dental health in serious jeopardy; or causing serious impairment to the Insured Person's dental functions; or causing serious dysfunction of any of the Insured Person's bodily organs or parts.

Experimental or Investigational Service means any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or the safety and efficacy of which have not been determined for use in the treatment of a particular dental condition for which it is recommended or prescribed.

Insured Person means a person under the age of 19 who is eligible and enrolled for benefits provided under the Policy.

Medically Necessary means those dental treatments or supplies which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating Physician to be consistent with the dental condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits, and alternatives.

Pediatric Dental Care means the Services specified in the Pediatric Dental Care Covered Charges provision for an Insured Person under the age of 19.

Urgent care services means services needed to prevent serious deterioration of an Insured Person's health resulting from an unforeseen illness or Injury for which treatment cannot be delayed.

Pediatric Vision Care Covered Charges

We will pay benefits for Covered Charges incurred by an Insured Person under the age of 19 for pediatric vision care. Covered Charges for Pediatric Vision Care are:

1. Comprehensive eye exam;
2. Prescription lenses and lens options;
3. Lenses: single vision, conventional bifocal, conventional trifocal, and lenticular; glass, plastic or polycarbonate; all lens powers;fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses; scratch-resistant coating. Coating and Special lenses: ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions),blended segment lenses, intermediate vision lenses, premium progressive lenses (Varilux, etc.), select or ultra progressive lenses, photocromic glass lenses, polarized lenses, anti-reflective coating (standard/premium/ultra), and high index lenses.
4. Eyeglass frames limited to one per each 12-month period.
5. A full year's supply of contact lenses is covered per year in lieu of eyeglasses. This benefit includes the evaluation, Contact Lens Fitting and Follow-up for contact lenses. The Insured Person under age 19 is eligible to select only one of either eyeglasses or contact lenses in each 12-month period.
6. Medically Necessary contact lenses when Preauthorization is obtained. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions:

    a. Anisometropia ;
    b. Keratoconus;
    c. Pathological Myopia;
    d. Aphakia;
    e. Aniseikonia;
    f. Aniridia;
    g. Corneal Disorders;
    h. Post-traumatic Disorders;

i. Irregular Astigmatism.

All Contact lenses that are Medically Necessary are covered and the list above is illustrative not exhaustive.

7. Low Vision services includes the following when Preauthorization is obtained:
   a. One comprehensive low vision evaluation once every 5 years
   b. Follow-up visits limited to four (4) visits in any five (5) Year period; and
   c. Low vision aids limited to the following:
      i. Spectacle-mounted magnifiers;
      ii. Hand-held and stand magnifiers;
      iii. Hand held or spectacle-mounted telescopes; or
      iv. Video magnification.

Pediatric Vision Care Limitations and Exclusions

In addition to the General Exclusions and Limitations section of the Policy and any limitations specified in the Schedule of Benefits, benefits for Pediatric Vision Care are limited as follows:

1. In no event will benefits exceed the lesser of:
   a. The limits shown in the Schedule of Benefits; or
   b. The Usual, Reasonable and Customary Charge.
2. Materials covered under the Policy that are lost, or stolen. Broken or damaged materials will only be replaced at normal intervals as specified in the Schedule of Benefits.
3. Basic cost for lenses and frames covered by the Policy. The Insured Person is responsible for lens options selected that are not shown above, including but not limited to:
   Groove, Drill or Notch, and Roll and Polish

Refer to the General Exclusions and Limitations section of this Certificate for additional exclusions. Unless specifically stated otherwise, no benefits for Pediatric Vision Care will be provided for, or on account of, the following items:

1. Orthoptic or vision training and any associated supplemental testing;
2. Two or more multiple pair of glasses, in lieu of bifocals or trifocals;
3. Any services and/or Materials required by an employer as a condition of employment;
4. Safety lenses and frames;
5. Contact lenses, when benefits for frames and lenses are received;
6. Cosmetic items;
7. Any services or Materials not listed as a Covered Charge or in the Schedule of Benefits;
8. Expenses for missed appointments;
9. Any charge from a Providers' office to complete and submit claim forms;
10. Non-prescription Materials or vision devices;
11. Costs associated with securing Materials;
12. Pre- and post-operative services;
13. Orthokeratology;
14. Routine maintenance of Materials;
15. Refitting or change in lens design after initial fitting;
16. Artistically painted lenses; or
17. Online purchase of complete pair of eyeglasses when not purchased through the In-Network Provider.

For the purposes of this Part only, the following definitions apply:

Comprehensive Eye Exam means an exam of the complete visual system which includes: case history; monocular and binocular visual acuity, with or without present corrective lenses; neurological integrity (pupil response); biomicroscopy (external exam); visual field testing (confrontation); ophthalmoscopy (internal exam); tonometry (intraocular pressure); refraction (with recorded visual acuity); extraocular muscle balance assessment; dilation as required; present prescription analysis; specific recommendation; assessment plan; and provider signature.

Contact Lens Fitting and Follow-up means an exam which includes: keratometry; diagnostic lens testing; instruction for insertion and removal of contact lenses; additional biomicroscopy with and without lens.

Insured Person means a person under the age of 19 who is eligible and enrolled for benefits provided under the Policy.

Low Vision means severe vision problems as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at all tasks.

Materials mean frames, and lenses and lens options, and/or contact lenses.

Pediatric Vision Care means the Services and Materials specified in the Pediatric Vision Care Covered Charges provision for an Insured Person under the age of 19.

Usual, Reasonable and Customary Charge means that portion of a Charge made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1. The customary Charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2. The usual Charge the Provider most frequently makes to patients for the same service.

We will base our determination of the Customary Charges within a geographical area on a study or survey done to determine such Charges. We use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by Providers for similar services based on the geographic area. This data is updated periodically.

If the Insured Person chooses a deluxe, designer or premier frame the Usual, Reasonable and Customary Charge will be limited up to the average cost of the comparable selection of non-deluxe, non-designer or non-premier frames.

If the Insured Person chooses specialty contact lenses, including, but not limited to, toric, multifocal and gas permeable lenses, the Usual, Reasonable and Customary Charge will be limited up to the least expensive regular contact lenses.

PART 7 – GENERAL EXCLUSIONS AND LIMITATIONS

The Policy contains certain exclusions and limitations as described. Charges for any services, supplies, and treatment as described below will not be considered as Covered Charges under the Policy and no benefits will be payable for such charges. The Policy does not provide any benefits for the following charges, treatment, services, care or supplies for or related to:

1. **Absence of Insurance** –Loss for which no charge would be made in the absence of health care coverage or for a service which Your Physician advertises as a free service.
2. **Addiction** –Caffeine addiction and non-chemical addictions including, but not limited to, gambling, sexual, spending, shopping, working and religious. This exclusion does not apply to Substance Use Disorders or Mental Health Conditions.
3. **Blood Storage** –The storage of blood, except for autologous collection in preparation for surgery.
4. **Certain exams and Services** - Physical exams and other Services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Physician determines that the Services are Medically Necessary.
5. **Commission of a Felony** –Treatment that results from the Insured Person's commission of a felony or being engaged in an illegal occupation.
6. **Cosmetic Services-** Services that are intended primarily to change or maintain an Insured Person's appearance, except that this exclusion does not apply to any of the following:
   a. Services covered under "Reconstructive Surgery" in PART 5 - COVERED CHARGES; and
   b. The following devices covered under "Prosthetic and Orthotic Devices" in PART 5 - COVERED CHARGES: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part.

   This exclusion also does not apply to complications resulting from a non-covered treatment or surgery.
7. **Custodial Care** - Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, or Inpatient hospital care.
8. **Dental and orthodontic Services** - Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following an accident and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment. This exclusion does not apply to services covered under the Pediatric Dental Benefit in PART 6 - PEDIATRIC AND DENTAL CARE COVERED CHARGES. This exclusion does not apply to dental and orthodontic services in preparation for radiation therapy, including dental evaluation, x-ray, fluoride treatment, and extractions necessary to prepare the jaw for radiation therapy of cancer in the head or neck.
9. **Disposable Supplies -** Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in PART 5 - COVERED CHARGES.
10. **Employment for Wage or Profit or Worker's Compensation –** An Insured Person may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether You are entitled to a Financial Benefit, but We may recover the value of any covered Services from the following sources:
    from any source providing a Financial Benefit or from whom a Financial Benefit is due.
11. **Employer Responsibility** – For any Services that the law requires an employer to provide, We will not pay the Employer, and when We cover any such Services We may recover the value of the Services from the Employer.
12. **Excess Charges** – Amounts above the Reasonable and Customary Charges for the services rendered by Out-of-Network Providers except as provided in the Policy.
13. **Experimental Treatment** –Services that are Experimental and Investigational in nature except for those services determined to be covered under the Independent Medical Review process.
14. **Family Members** –Treatment or services performed by a member of Your family or any person who regularly lives in Your home. Family members include You, Your spouse, Your Domestic Partner, Your Domestic Partner's parent, children, sisters and brothers; Your spouse's parents, children, sisters, and brothers.
15. **Federal Facility** –Treatment, diagnosis, or care provided while confined in a federal facility, unless You are legally obligated to pay the charges for such confinement.
16. **Foreign Travel and Residency** Treatment, drugs or medical care received outside the United States or its possessions, unless expenses are incurred to treat an Emergency Medical Condition.

17. **Government Agency Responsibility** - For any Services that the law requires be provided only by or received only from a government agency, We will not pay the government agency, and when We cover any such Services We may recover the value of the Services from the government agency.
18. **Hair Loss Or Growth Treatment** – Items and Services for the promotion , prevention, or other treatment of hair loss or hair growth.
19. **Hearing Aids**
20. **Homeopathy**
21. **Hypnosis** – expenses related to hypnosis, including its use in place of anesthesia.
22. **Internet** – expenses related to treatment, diagnosis, or care provided over the Internet, or via electronic mail, unless such consultation or treatment qualifies as Telemedicine under California law.
23. **Items and services that are not health care items and services** - For example, We do not cover:
    a. Teaching manners and etiquette;
    b. Teaching and support services to develop planning skills such as daily activity planning and project or task planning;
    c. Items and services that increase academic knowledge or skills;
    d. Teaching and support services to increase intelligence;
    e. Academic coaching or tutoring for skills such as grammar, math, and time management;
    f. Teaching an Insured Person how to read, whether or not an Insured Person have dyslexia;
    g. Educational testing;
    h. Teaching art, dance, horse riding, music, play or swimming;
    i. Teaching skills for employment or vocational purposes;
    j. Vocational training or teaching vocational skills;
    k. Professional growth courses;
    l. Training for a specific job or employment counseling;
    m. Aquatic therapy and other water therapy;
    n. Work hardening or strengthening programs;
    o. Travel expenses;
    p. Self-help training;
    q. Services or supplies at a health spa or similar facility
    r. A personal trainer;
    s. Personal hygiene and convenience items;
    t. Water aerobics and cybex machines;
    u. Television, telephone, cots and visitors' meals; or
    v. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form and information required to process Your claims and similar expenses.
24. **Items and services to correct refractive defects of the eye** - Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.
25. **Massage therapy** unless part of a physical therapy course of treatment.
26. **Oral nutrition** - Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food. This exclusion does not apply to any of the following:
    a. Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section.
    b. Enteral and parenteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section.
27. **Private Duty Nursing services** – Except when such services are required for Home Health Care.
28. **Refractive Defects** – Eye surgery to correct refractive defects for Insured Persons of all ages.
29. **Research** –Research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research or clinical-research study.
30. **Robotic Assisted Surgery Services**.
31. **Routine Foot Care Items And Services** – Routine foot care items and Services that are not Medically Necessary.
32. **Services Related To A Noncovered Service** - When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services We would otherwise cover to treat complications of the noncovered Service. For example, if You have a noncovered Cosmetic Surgery, We would not cover Services You receive in preparation for the surgery or for follow-up care. If You later suffer a complication such as a serious infection, this exclusion would not apply and We would cover any Services that We would otherwise cover to treat that complication.

33. **Surrogacy** - Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to an Insured Person who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy Arrangements" under PART 3 – MEDICAL MANAGEMENT for information about Your obligations to Us in connection with a surrogacy arrangement, including Your obligation to reimburse Us for any Services We cover.
34. **Sexual dysfunctions** or inadequacies, except for outpatient prescription drugs for the treatment of sexual dysfunction disorders.
35. **Travel and Lodging Expenses –** This exclusion does not apply to reimbursement for travel and lodging expenses provided under Bariatric Surgery and Transplants in PART 5 - COVERED CHARGES.
36. **Vision** – Radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy,unless Medically Necessary.

PART 8 – COORDINATION OF BENEFITS

Applicability

1. This Coordination of Benefit ("COB") provision applies to the Policy ("This Plan") when an Insured has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules ("Rules") should be looked at first. Those Rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
   a. shall not be reduced when, under the Rules, This Plan determines its benefits before another Plan; but
   b. may be reduced when, under the Rules, another Plan determines its benefits first.

Definitions

1. "Plan" is any of the following which provides benefits or services for, or on account of, medical or dental care or treatment:
   a. Group insurance or group-type coverage, whether insured or uninsured. This includes: prepayment, group practice or individual practice coverage,. It does not include: student accident type coverage;
   b. Coverage under a governmental plan or required or provided by law. This does not include a Medi-Cal benefits under Chapter 7 (commencing with Section 14000 Welf. & Inst.) or Chapter 8 (commencing with Section 14500 Welf. & Inst.) of Part 3 of Division 9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code(as amended from time to time.) It also does not include any plan when, by law, its benefits are in excess of those of any private program or other non-governmental program.

   Each contract or other arrangement for coverage under A. or B. above is a separate Plan. Also, if an arrangement has two parts and COB rule applies only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is the part of the Policy that provides benefits for health care expenses.

3. "PRIMARY PLAN"/"SECONDARY PLAN." The Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan: (a) may be a Primary Plan as to one or more other Plans; and (b) may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense." This means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition. That is unless the patient's stay in a private Hospital room is Medically Necessary either: (a) in terms of generally accepted Medical practice; or (b) as precisely defined in the Plan.

   A Plan might provide benefits in the form of services. In this case the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period." This means a Year. But, it does not include any part of a year: (a) during which a person has no coverage under This Plan; or (b) before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
   a. the other Plan has Rules coordinating its benefits with those of This Plan;
   b. both those Rules and This Plan's Rules, in item 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. Rules. This Plan decides its order of benefits using the first of the following rules which applies:
   a. Non-Dependent/Dependent. The benefits of the Plan that covers the person, other than as a dependent, are determined before those of the Plan that covers the person as a dependent except that, if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      1) secondary to the Plan covering the person as a dependent; and
      2) Primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.
   b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 2. c. below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
      1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
      2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

      However, the other Plan may not have the rule described above. Instead it may have a rule based upon the gender of the parent. If so, and if, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will decide the order of benefits.
   c. Dependent Child/Separated or Divorced Parents. Two or more Plans may cover a person as a dependent child of divorced or separated parents. In this case benefits for the child are determined in this order:
      1) first, the Plan of the parent with custody of the child;
      2) the Plan of the spouse or Domestic Partner of the parent with the custody of the child; and finally
      3) the Plan of the parent not having custody of the child.

      However, the specific terms of a court decree might state that one of the parents is responsible for the health care expenses of the child. In this case if the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This item does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   d. Dependent Child/Joint Custody. If the court decree awards joint custody, then benefits are paid as in 2.b. above.
   e. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (nor as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent.) The other Plan might not have this rule. If so, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
   f. Longer/Shorter Length of Coverage. If none of the above rules decides the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter time.
   g. Continuation Coverage: If a person whose coverage is provided under a right of continuation plan pursuant to federal or state law and also under this Plan, the following order of benefits applies:
      1) First, the Plan covering the person as an employee, or as the employee's dependent;
      2) Second, the benefits of the continuation coverage.

   If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.

Effect on the Benefits of this Plan

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

   exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information
Certain facts are needed to apply these COB rules. We have the right to decide which facts We need and to obtain them from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

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

Right of Recovery
The amount of the payments made by Us might be more than We should have paid under this COB provision. In such a case, We may recover the excess from one or more of these:

1. Any persons to, or for whom, such payments are made; or
2. Any insurance companies; or
3. Any other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services. The right of recovery does not include liability settlements. However, the right will not apply unless the Insured Person, whose loss is the basis for applying such provision, is made whole.

Any such right of reimbursement provided to Us under the Policy shall not apply or shall be limited to the extent that states or the state courts eliminate or restrict such rights.

Medicare Coordination
1. Claims will be coordinated with Medicare based on the Medicare Secondary Payor (MSP) Rules.

2. If the Insured Person is retired or on COBRA, Medicare is the Primary Plan and this Plan will be secondary for the Employee and the Employee's enrolled Dependents who are age 65 or over or eligible for Medicare because of disability. Medicare is considered a Plan for the purposes of Coordination of Benefits. The Plan will coordinate benefits with Medicare whether or not the Insured Person or the Insured Person's enrolled Dependents are actually receiving Medicare benefits.

3. The Plan is the Primary Plan and Medicare will be the Secondary Plan for an Employee and the Employee's enrolled Dependents during the first thirty (30) months in which the Employee or the Covered Dependent spouse or Domestic Partner or child(ren) is/are eligible for Medicare solely because of permanent kidney failure. After the first thirty (30) months, Medicare will be the Primary Plan and this Plan will be the Secondary Plan. Medicare will be considered a Plan for purposes of Coordination of Benefits. This Plan will coordinate benefits with Medicare whether or not the Insured Person or his Dependent spouse or Domestic Partner or child is/are actually receiving Medicare benefits.

PART 9 – PREMIUM PAYMENT

Payment Of Premium
Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period.

Grace Period
The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

Premium Changes
We reserve the right to change premiums under the Policy on any premium due date by giving the Employer at least 31 days prior written notice. The premium rates will only be changed when the Policy is up for renewal.

If the Employer has selected a rate guarantee period when applying for coverage under the Policy, the premium will not change during the rate guarantee period except for the following reasons:

1. The addition or deletion of Employees to or from the coverage under the Policy;
2. An Employee enters into a new age rate-band;
3. The Employer changes the network to a network that is different than the network the Employer selected when applying for coverage;
4. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
5. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
6. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

PART 10 – RENEWABILITY AND TERMINATION

Renewability Of the Policy
The Policy is guaranteed renewable at the option of the Employer, except for the following reasons:

1. Non-payment of premiums;

   Fraud or intentional misrepresentation of a material fact by the Employer. After 2 years following the issuance of this Policy, We will not rescind the Policy for any reason, and shall not cancel the Policy, limit any of the provisions of the Policy, or raise premiums on the Policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.
2. For failure to comply with a material Policy provision relating to employer participation requirements;
3. For failure to comply with a material Policy provision relating to employer contribution requirements;
4. The type of coverage under the Policy is no longer offered by Us in the state in which the Employer originally obtained coverage in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the small group market in that state; or
5. We decide to discontinue offering all health insurance in the small group market in the state where the Employer originally obtained coverage under the Policy for his or her Employees in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the small group market in that state and will not renew coverage.

Termination Of Employee's Coverage
Coverage for an Insured Employee shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The date You or Your Employer fails to pay the required premium;
3. The date You no longer meet the definition of Employee.

   If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing in order to obtain coverage for a Service, Your coverage and Your Dependent's coverage will terminate immediately upon written notice of termination delivered by Us to You. However, if You commit fraud or make an intentional misrepresentation of material fact in writing on Your enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage and Your Dependent's coverage will have a retroactive effect to Your Effective Date under the Policy. After 2 years following the issuance of this Policy, We will not rescind the Policy for any reason, and shall not cancel the Policy, limit any of the provisions of the Policy, or raise premiums on the Policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. We will provide You at least 30 calendar days advance written notice of any rescission of insurance coverage;; or
4. The date of Your death.

Termination Of Dependent Insurance
Coverage for an Insured Employee with respect to Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy;
2. The date Your insurance terminates;
3. The date You or Your Employer fails to pay the required premium;
4. With respect to an Insured Employee's Dependent spouse or Domestic Partner, the premium due date coinciding with or next following the date on which the Insured Employee is divorced or legally separated from such spouse or the civil union or domestic partnership between the Insured Employee and spouse or Domestic Partner is terminated; or
5. The premium due date coinciding with or next following the date on which a Dependent child no longer qualifies under the definition of Dependent. If upon attaining the limiting age specified in the definition of Dependent, a Dependent child, because of Mental or Physical Incapacity, as defined below, is incapable of earning his or her own living and is chiefly Dependent upon the Employee for support and maintenance, coverage for the Dependent child may be continued during the continuance of such incapacity, provided that:

   a. Medical proof, in writing, of such incapacity must be given to Us within thirty-one (31) days after the date on which the Dependent child attains the limiting age;

   b. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us at any time during the first two (2) years of such continuance and not more than once each year thereafter;

   c. You continue paying the required premium for the Dependent; and

   d. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described above.

   Mental or Physical Incapacity, as used herein, means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months in duration.

Modifications
We may modify the Policy and this Certificate if the modification occurs at the time of coverage renewal and only if the modification is an uniform modification of coverage and the required notice will be provided.

Continuation of Group Coverage

COBRA
You may be able to continue Your coverage under the Policy for a limited time after You would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If Your Employer is subject to COBRA and You are eligible for COBRA coverage, in order to enroll You must submit a COBRA election form to Your Employer within the COBRA election period. Please ask Your Employer for details about COBRA coverage, such as how to elect coverage, how much You must pay for coverage, when coverage and premiums may change, and where to send Your premium payments.

You may be able to convert to an individual (nongroup) plan if You don't apply for COBRA coverage, or if You enroll in COBRA and Your COBRA coverage ends. Also, if You enroll in COBRA and exhaust the time limit for COBRA coverage, You may be able to continue group coverage under state law as described under "Cal-COBRA".

Cal-COBRA

If You are eligible for Cal-COBRA, You can continue coverage as described in this "Cal-COBRA" section if You apply for coverage in compliance with Cal-COBRA law and pay applicable premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA (COBRA extension). If Your Employer is subject to COBRA and Your COBRA coverage ends, You may be able to continue group coverage effective the date Your COBRA coverage ends if all of the following are true:

Your effective date of COBRA coverage was on or after January 1, 2003

You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months

You do not have Medicare

You must request an enrollment application by calling Us within 60 days of the date of when Your COBRA coverage ends.

You may be able to convert to an individual (nongroup) plan if You don't apply for Cal-COBRA coverage, or if You enroll in Cal-COBRA and Your Cal-COBRA coverage ends.

Eligibility and effective date of coverage for Cal-COBRA. If Your Employer is not subject to COBRA, an Insured Person may be able to continue uninterrupted group coverage under the Policy if all of the following are true:

Your employer meets the California definition of "small employer".

Your employer employed between 2 to 19 eligible employees on at least 50 percent of its working days during the last calendar year.

An Insured Person does not have Medicare Part A

An Insured Person experiences one of the following qualifying events:

Coverage is through an Employee who dies, divorces, legally separates, or gets Medicare;

An Insured Person no longer qualifies as a Dependent;

You are an Employee or an Insured Person’s coverage is through an Employee, whose employment terminates (other than for gross misconduct) or whose hours of employment are reduced.

You must request an enrollment application by calling Us within 60 days of the date of a qualifying event described above.

You may be able to convert to an individual (nongroup) plan if You don't apply for Cal-COBRA coverage, or if You enroll in Cal-COBRA and that Cal-COBRA coverage ends.

Cal-COBRA enrollment and premiums. Within 10 days of Your request for an enrollment application, We will send You Our application, which will include premium and billing information. You must return Your completed application within 63 days of the date of Our termination letter or of Your coverage termination date (whichever date is later).

If We approve Your enrollment application, We will send You billing information within 30 days after We receive Your application. You must pay the bill within 45 days after the date We issue the bill. The first premium payment will include coverage from Your Cal-COBRA effective date through Our current billing cycle. You must send Us the premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, monthly premium payments are due on or before the last day of the month preceding the month of coverage. The premiums will not exceed 110 percent of the applicable premiums charged to a similarly situated individual under the Policy except that premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent.

Changes to Cal-COBRA coverage and premiums. Your Cal-COBRA coverage is the same as for any similarly situated individual under Your Employer's Policy, and Your Cal-COBRA coverage and premiums will change at the same time that coverage or premiums change in Your Employer's Policy. Your Employer's coverage and premiums will change on the renewal date of the Policy, and may also change at other times if the Policy is amended. Your monthly invoice will reflect the current premiums that are due for Cal-COBRA coverage, including any changes. For example, if Your Employer makes a change that affects premiums retroactively, the amount We bill You will be adjusted to reflect the retroactive adjustment in premiums. Your Employer can tell You whether this Certificate is still in effect and give You a current one if this Certificate has expired or been amended. You can also request one from Us.

Termination for nonpayment of Cal-COBRA premiums. If We do not receive the full amount of Your family's premium payment on or before the last day of the month preceding the month of coverage, We will terminate the coverage of everyone in Your family effective on the last day of the month for which We received a full premium payment. This retroactive period will not exceed 60 days before the date We mail You a notice confirming termination of coverage. If We do not receive full premium payment on or before the last day of the month preceding the month of coverage, We will send a Notice of Termination (notice of nonreceipt of payment) to You. We will mail this notice at least 15 days before any termination of coverage and it will include the following information:

A statement that We have not received full premium payment and that We will terminate the coverage of everyone in Your family for nonpayment if We do not receive the required premiums within 15 days after the date We mailed the notice confirming termination of coverage.

The date and time when the coverage of everyone in Your family will end if We do not receive the premiums.

We will terminate Your family's coverage if We do not receive payment within 15 days of the date We mailed the Notice of Termination (notice of nonreceipt of payment). We will mail a notice confirming termination of coverage, which will inform You of the following:

That We have terminated the coverage of everyone in Your family for nonpayment of premiums;

The date and time when the coverage of everyone in Your family ended;

Information explaining whether or not You can reinstate Your coverage.

Reinstatement of Your coverage after termination for nonpayment of Cal-COBRA premiums. If We terminate Your coverage for nonpayment of premiums, We will permit reinstatement of Your coverage twice during any 12-month period if We receive the amounts owed within 15 days of the date the notice confirming termination of coverage was mailed to You. We will not reinstate Your coverage if You do not obtain reinstatement of Your terminated coverage within the required 15 days, or if We terminate Your coverage for nonpayment of premiums more than twice in a 12-month period.

Termination of Cal-COBRA coverage. Cal-COBRA coverage continues only upon payment of applicable monthly premiums to Us at the time We specify, and terminates on the earliest of:

The date Your Employer's Policy with Us terminates (You may still be eligible for Cal-COBRA through another Group health plan).

The date You get Medicare.

The date You become covered, or could have become covered, under COBRA.

Either the date that is 36 months after the date of Your original Cal-COBRA qualifying event or the date that is 36 months after the date of Your original COBRA effective date (under this or any other plan) if You were enrolled in COBRA before Cal-COBRA.

The date Your coverage is terminated for nonpayment of premiums.

Note: If the Social Security Administration determined that You were disabled at any time during the first 60 days of COBRA coverage, You must notify Your Employer within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that You are no longer disabled in the 35th or 36th month of group continuation coverage, Your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after Your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify Us within 30 days after You receive Social Security's final determination that You are no longer disabled.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If You are called to active duty in the uniformed services, You may be able to continue Your coverage under the Policy for a limited time after You would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to Your Employer within 60 days after Your call to active duty. Please contact Your Employer to find out how to elect USERRA coverage and how much You must pay for Your coverage.

Coverage for a disabling condition

If You became Totally Disabled while You were covered as an Employee and Your Employer's Policy with Us terminated, We will cover Services for Your totally disabling condition until the earliest of the following events occurs:

12 months have elapsed since Your Employer's Policy with Us terminated.

You are no longer Totally Disabled.

Your Employer's Policy with Us is replaced by another group health plan without limitation as to the disabling condition.

Your coverage will be subject to the terms of the Policy including Cost Sharing, but We will not cover Services for any condition other than Your totally disabling condition.

For Employees and adult Dependents, "Totally Disabled" means a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light ofhis age, education, training, experience, station in life, physical and mental capacity.

For Dependent children, "Totally Disabled" means that a condition is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the condition makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for Your disabling condition, You must notify Us within 30 days after Your Employer's Policy with Us terminates.

PART 11 – GENERAL PROVISIONS

Entire Contract - Changes

The policy and the application of the Employer constitute the entire contract between the parties. Any statement made by the Employer shall, in the absence or fraud, be deemed a representation and not a warranty. No statement made by any Employee whose eligibility has been accepted by Us will be used in defense to a claim hereunder.

Incontestability

The validity of the Policy will not be contested, except for non-payment of premiums, after it has been in force for 2 years from the Date of Issue.

Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with Federal laws or any applicable state law is hereby amended to meet the minimum requirements of the law.

Ambiguities
Any terms or conditions specified in the Policy that are determined to be ambiguous or in conflict with State or Federal laws shall be considered separately and shall not void or effect the legality of the remaining terms and conditions that are included in the Policy and this Certificate.

Physical Examination
We have the right, at Our own expense, to have an Insured Person for whom claim Is made examined as often as is reasonable while a claim is pending under the Policy.

Workers' Compensation
The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

Certificates/Booklets
We will issue to the Employer a Certificate for delivery to each Insured Employee.

Waiver Of Rights
If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information
The Insured Person agrees to provide to Us any information or data that We reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care Providers from whom the Insured Person has received treatment or services, documentation of prior Creditable Coverage, marriage license, domestic partnership, documentation of adoption, documentation of legal custody of a Dependent, student status information, and treating Provider statements.

Effective Date
No insurance under the Policy shall become effective until notice in writing is given to the Employer by Us. Issuance of a Certificate with a Validation of Coverage face page will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

Misstatement of Age
If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums..

Change of Beneficiary
Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy, to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

PART 12 – CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at Company [c/o Meritain Health, 1405 Xenium Lane North Ste 140, Minneapolis, MN 55441][21] or to any authorized agent of Ours, with information sufficient to identify the Insured, will be deemed notice to Us.

Claim Forms: Upon receipt of written notice of claim, We will furnish the required forms (if any) for filing proof of loss. If We do not send the forms within 15 days, You can satisfy Our requirements by giving Us a written statement. The statement should include the nature and extent of the claim, and be sent to Us in accordance with the proof of loss provision.

Proof of Loss: Written proof of loss must be furnished to Us, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured, later than one year from the time proof is otherwise required.

Timely Payment of Claims: We will pay all benefits due for Covered Charges, promptly upon receipt of due proof of loss. We will pay or deny benefits within 30 business days of receipt of due written proof of loss, or if due written proof of loss is not received with a claim, We will contest the claim within 30 business days of its receipt. If We fail to pay, deny or contest within those time periods, We will pay interest on any benefits payable at the rate of 10 percent per annum beginning on the first calendar day after the 30 business day period.

Assignment of Claims: All benefits payable will be payable to You unless a written assignment of benefits is filed with Us at Our administrative office. We will not be responsible for the legal effect of any assignment except for direct payments described in the Payment of Claims provision.

Payment of Claims: All benefits for Covered Charges are payable to You unless You have otherwise assigned the benefits to a medical Provider. Direct payment will be made for ambulance services, nuse midwives and nurse practitioners perinatal services, and midwives perinatal services.

If any such benefits remain unpaid at Your death, or, if You are, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse, Domestic Partner, mother, father, child, brother or sister. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

If any such benefits are payable to the estate of the Insured Person, or if the Insured Person is a minor or is, in Our opinion, legally incapable of giving valid receipt and discharge of any payment, We may, at Our option, pay an amount not exceeding $1,000.00 to any relative by blood or marriage or domestic partnership of the Insured Person or beneficiary, who is considered by Us to be equitably entitled thereto. Any payment so made will constitute a complete discharge of Our obligations to the extent of that payment, and We will not be required to see to the application of the money so paid.

Legal Action

No action at law or in equity will be brought to recover under the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy, nor will any action be brought after 3 years from the date the claim was first incurred.

Recovery of Overpayments

We reserve the right to deduct from any future benefits payable under the Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or intentional misrepresentation of a material fact made to obtain coverage under the Policy within 2 years after the Effective Date; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any policy or act of law providing Worker's compensation or similar coverage for occupational accidents or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person if claim payments previously were made with respect to such Insured Person.

Loss Alleged To Be Caused By Third Parties

If You obtain a judgment or settlement from or on behalf of a third party who allegedly caused a loss for which You received Covered Charges, You must pay Us Charges for those Services, except that the amount You must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This loss alleged to be caused by third parties" section does not affect Your obligation to pay Cost Sharing for these Services, but We will credit any such payments toward the amount You must pay Us under this paragraph.

To secure Our rights, We will have a lien on the proceeds of any judgment or settlement You or We obtain against a third party. The proceeds of any judgment or settlement that You or We obtain shall first be applied to satisfy Our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages You incurred.

PART 13 - GRIEVANCE RIGHTS AND PROCEDURES

Claim Inquiries: Please contact Our Customer Service Department at [1-800-123-4567][22] with any questions about the processing of Your claim, including coverage and benefit determinations and Grievance Reviews.

Grievance Reviews: If You disagree with a coverage or benefit determination, You have the right to file a Grievance about that determination within 180 calendar days from the date You received the coverage or benefit determination.

Grievance Review Instructions and Procedures:

1. To submit a Grievance, please
   a. State Your request for a Grievance review in writing, include Your full name, date of birth and certificate number, identify the claim in question, and explain why You disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.
   b. Sign and date Your written request and attach all supporting documentation.
   c. Mail the written request and attachments to the following address, within the 180-day deadline stated above:

      Claims Dept, Attn: Grievance Reviews
      National Health Insurance Company [c/o Meritain Health
      1405 Xenium Lane North Ste 140
      Minneapolis, MN 55441][23]

2. Upon request and at no charge, You may have reasonable access (including copies) to all documents, records and information submitted to Our office that relates to Your claim, including clinical rationale or review criteria.
3. The Grievance review will take into account all written comments, documents, records and other information submitted to Our office that relate to Your claim, including such comments, documents, records or other information not previously considered or not submitted at the time the claim was processed.
4. The Grievance review will be a "fresh" look at Your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination and not supervised by someone involved in that determination.
5. If the appealed determination is based on a medical judgment (in whole or in part), the Grievance review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination and not supervised by someone involved in that determination.
6. You or Your Physician may request a Grievance review, and You may be represented by a relative, friend or lawyer.
7. Within 5 business days of receiving Your written request, Our office will mail a written acknowledgement to You.
8. Within 30 calendar days of receiving Your written request, Our office will mail a written determination to You.

Additional Grievance Review Available:

1. If You disagree with the Grievance review determination, You may voluntarily request a second Grievance review. To exercise this second and final right to file a Grievance, You must submit another written request for a Grievance review to Our office within 180 calendar days from the date You received the determination for the first Grievance review. Please refer to the Grievance review instructions and procedures stated above for completing and submitting a written request for a second Grievance review. NOTE: A SECOND GRIEVANCE REVIEW IS COMPLETELY VOLUNTARY AND IS NOT NECESSARY IN ORDER TO EXHAUST ALL ADMINISTRATIVE RIGHTS OF APPEAL UNDER THE POLICY OR TO REQUEST AN INDEPENDENT MEDICAL REVIEW.
2. If You disagree with any Grievance review determination (first or second), You have a right under California state law to request an Independent Medical Review of Your claim. Our office will mail written notice of that right (see below) on or before Our receipt of Your initial request for a Grievance review, and an application form will be enclosed with each Grievance review determination. Strict time limits within which to request an Independent Medical Review apply.

State Assistance:
You have the right to request assistance from, or to file a complaint with, the California Department of Insurance at any time. Please note the following contact information:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower, Los Angeles CA 90013
800-927-HELP (in CA),
213- 897-8921 (outside CA).
www.insurance.ca.gov

Prior and Concurrent Reviews
Medical Necessity decisions for services prior to (prior review) or during the course of care (concurrent reviews) will be made within 5 business days of receipt of all necessary information. Notice of the decision shall be communicated to the requesting provider within 24 hours of the decision and to You within 2 business days of the decision. In the case of concurrent review, care will not be discontinued until the Insured Person's treating provider has been notified of Our decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the Insured Person.

Retrospective Reviews
If We have all information necessary to make a Medical Necessity determination regarding a retrospective claim, We will make a determination and notify You, Your designee, if any, and Your Provider within 30 calendar days of the receipt of the request.

Expedited Review Process for Urgent Claim
An urgent care claim is a pre-service claim where the application of the time period for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.

If all of the information needed to process your claim is provided to Us, your claim will be processed as soon as possible. However, the processing time needed will not exceed 72 hours.

If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the time limits described above in the Grievance Review Instructions and Procedures. When the additional information needed to decide an urgent care claim is requested orally, it will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to Us as requested. The normal processing period will be extended by the time it takes you to provide the information, and the limit will start to run once We have requested the information and received a response to Our request. If you do not provide the missing information within 48 hours for an urgent care claim, We will make a decision on your claim without it, and your claim could be denied as a result.

Judicial Review:
If You disagree with a Grievance review determination, You have the right to bring a civil action under California state law (if benefits have been denied based on Medical Necessity, You must first exhaust all rights to an Independent Medical Review under California state law). The time limitations stated in this Certificate for bringing legal actions or proceedings apply to any such civil action.

NOTICE OF RIGHT TO AN INDEPENDENT MEDICAL REVIEW

You have the right to request Independent Medical Review from the California Department of Insurance. This NOTICE contains important information about Your insurance claim and Your RIGHT TO SEEK INDEPENDENT MEDICAL REVIEW of the coverage or benefit determination under the Department's Independent Medical Review System. Please carefully read the following instructions on how to request an Independent Medical Review, pursuant to California law. If You have any questions about submitting Your written request, please call Our Customer Service Department at [1-800-847-8361][24].

IMPORTANT: You must submit Your request within the time period explained below.

Independent Medical Review Process

A. Eligibility

You may apply to the Independent Medical Review System if:

- You are a resident of California;
- Benefits have been denied, modified or delayed (in whole or in part) for any health care service, due to a finding that the service is not Medically Necessary ("Disputed Health Care Service");
- The denial of benefits is not substantially based on a finding that provision of the health care services is excluded from coverage under the terms and conditions of the Policy ("Coverage Decision");
- You have completed the Grievance review process and You contest the determination (or Your grievance remains unresolved and it was submitted more than 30 days ago); and
- It has been no more than 6 months since You received the Grievance review determination (or, if Your Grievance remains unresolved, no more than 6 months and 30 days since You submitted the Grievance). The Commissioner of the California Department of Insurance may extend the application deadline if warranted by circumstances.

B. Application

If You are eligible to obtain an Independent Medical Review, You may apply by completing the application form and using the addressed envelope enclosed with the Grievance review determination, or by mailing a written request to either the:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles CA 90013
800-927-HELP (in CA)
213- 897-8921 (outside CA)

or, the following address (upon receipt, the request will be forwarded to the California Department of Insurance):

Claims Dept, Attn: Grievance Reviews
National Health Insurance Company [c/o Meritain Health
1405 Xenium Lane North Ste 140;
Minneapolis, MN 55441][25]

There are no application or review fees or charges for You to pay.

C. Review Procedures

The California Department of Insurance will, at the time of the receipt of the request for an Independent Medical Review, assign an Independent Medical Review Organization (IMRO) from the list of certified IMROs and will so inform the insurer.

If the request for an Independent Medical Review is not based on a Disputed Health Care Service, but on a Coverage Decision, the California Department of Insurance will instead conduct the review. If there is ambiguity as to what entity should conduct the review, the review will be conducted by an IMRO.

The IMRO will have 30 days to review once all the information is gathered unless the request involves an inminet and serious threat to health which can be expedited and a decision rendered in 3 days.

Within 3 business days after the date on which We receive notice of the IMRO from the California Department of Insurance, We will provide to the assigned IMRO all documents and information utilized in making the Disputed Health Care Service, as well as the final written decision from the insurer, including:

- A copy of all of Your medical records in Our possession relevant to Your medical condition, the health care services being provided for that condition, and the Disputed Health Care Services.
- Any newly developed or discovered relevant medical records in Our possession after the initial documents are provided to the IMRO shall be forwarded immediately to the IMRO independent medical review, with copies forwarded to You (or Your provider, if authorized by You), unless declined or otherwise prohibited by law.
- A copy of all information provided to You by Us concerning Our and Your provider decisions regarding Your condition and care, and a copy of any materials You or Your provider submitted to Us in support of Your request for the Disputed Health Care Services. This documentation shall include the Grievance review determination.

- A copy of any other relevant documents or information used by Us in determining whether the Disputed Health Care Services should have been provided, and any statements by Us explaining the reasons for the decision to deny benefits for the Disputed Health Care Services on the basis of Medical Necessity, with copies forwarded to You (or Your provider, if authorized by You), unless declined, prohibited by law, or the Commissioner of the California Department of Insurance determines it to be legally privileged information.

The California Department of Insurance and the IMRO shall maintain the confidentiality of any information found by the Commissioner to be proprietary information of Ours and the confidentiality of all Your medical record information shall be maintained pursuant to applicable state and federal laws.

D. External Review – Experimental or Investigational Therapies

Our decision to deny, delay, or modify experimental or investigational therapies shall be subject to the independent medical review process, except that, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence.

E. Confidentiality

Your medical records provided to Us and the IMRO and the findings and recommendations of the IMRO are confidential and will be used only by the California Department of Insurance, the IMRO, and Us. The medical records and findings and determinations will not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate and will not be included under any materials available to public inspection.

We may at any time determine to provide the requested medical services by so notifying the IMRO or the California Department of Insurance, and You. Such notification will terminate the Independent Medical Review process.