FEDERATED MUTUAL
INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP HEALTH POLICY

Policy Holder: **LIVONIA AUTOMOTIVE SALES & SER**

Policy Effective Date: **DECEMBER 1, 2014**
at 12:01 a.m. Central Standard Time

Policy Anniversary: DECEMBER 1, 2015 and annually each year thereafter.

Policy Number: **9303**

This policy is delivered in Michigan and is governed by its laws.

CONSIDERATION. The **policy** is issued to the **policyholder** in consideration of the application and payment of premiums.

MEMBER OF THE COMPANY. By virtue of this **policy**, the **policyholder** is a member of Federated Mutual Insurance Company. **Our** annual meetings are held at the Home Office on the third Tuesday in April at 10:00 A.M.

Secretary

President

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LIVONIA AUTOMOTIVE SALES & SERVICE / LCJ INC

Summary of Benefits and Coverages

The Affordable Care Act requires all health insurers to provide applicants, enrollees, policyholders and certificate holders with a Summary of Benefits and Coverage (SBC) summarizing coverage available under the health insurance policy. All health insurers are required to present the information in a format established by the U.S. Department of Health and Human Services.

You can access the SBC for health insurance policies offered by Federated by going to: www.federatedinsurance.com/Employer/SBC or www.federatedinsurance.com/Member/SBC. Select your policy state and plan number to see the SBC for that health insurance policy. The SBC will provide a link to a provider network (PPO) locator where you will select your state of residence and your PPO for provider information in that network. Your policy state, plan number and PPO are listed below.

Policy State:	MICHIGAN
Plan Number:	9303
PPO:	COFINITY

If you would like to receive a free paper copy of the SBC for a specific health insurance policy you can call 1-877-612-4477. Spanish (Español): Para obtener asistencia en Español, llame al 1-877-612-4477.

Please Keep for Your Records

Federated Mutual Insurance Company
Federated Service Insurance Company*
Federated Life Insurance Company
Home Office: 121 East Park Square, Owatonna, Minnesota 55060
Phone: (507) 455-5200 www.federatedinsurance.com
*Federated Service Insurance Company is not licensed in the states of NH, NJ, RI, and VT.

FEDERATED INSURANCE®
It's Our Business to Protect Yours®

SCHEDULE OF BENEFITS

Effective Date: **DECEMBER 1, 2014**

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions or below.

1. Payment of **benefits** for **covered expenses** are subject to the following:

	Network Provider	Non-Network Provider
Deductible - Individual	$1,500	$1,500
Deductible - Family	$3,000	$3,000
Coinsurance	20%	45%
Out-of-Pocket Maximum - Individual	$3,500	$6,000
Out-of-Pocket Maximum - Family	$7,000	$12,000

2. Pre-certification Requirements

   See Section I - General Provisions, 16. Pre-certification Requirements for details on the process.

   Pre-certification is required for the following services:

   a. **durable medical equipment**;
   b. diagnostic services:
      i. CAT scan,
      ii. MRI,
      iii. PET scan, and
      iv. sleep studies;
   c. **home health care services**;
   d. **hospice care services**;
   e. **inpatient** treatment in a **hospital**;
   f. **inpatient** stays for maternity services over the minimum duration listed;
   g. **inpatient** or transitional treatment for **chemical dependency** or **mental illness**;
   h. mastectomy;
   i. **nursing facility** services;
   j. **orthotic devices**;
   k. **prescription drugs** on the prior authorization list;
   l. **prosthetic devices**;
   m. rehabilitative services;
   n. **surgeries**;
   o. therapies:
      i. **physical therapy**,
      ii. **occupational therapy**,
      iii. **speech therapy**, and
      iv. intravenous therapy; and
   p. transplant services.

3. Definitions

   a. **Brand name drug**

      means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

   b. **Coinsurance**

      means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**. **Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before **we** will begin paying **benefits** in that **calendar year**. **Copayments** do not apply toward satisfying the **deductible**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

The individual **deductible** is the most each individual **covered person** must pay each **calendar year** before **we** will begin paying **benefits** for that **covered person** in that **calendar year**. However, if the family **deductible** is satisfied the **benefits** will be paid for the **covered employee** and his covered **dependents** even if their individual **deductibles** are not satisfied.

Any amount the **covered person** pays for **covered expenses** in the last three **months** of the previous **calendar year** which are applied to that **calendar year's deductible** will be carried over and applied to the current **deductible**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer's** coverage first becomes effective with **us**, any amount which was applied to the **deductible** for that **covered person** under the **employer's** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic Drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

i. the same active ingredients, strength and dosage form; and

ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses** other than **prescription drugs**. **Copayments**, **prescription drug copayments**, expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

The individual **out-of-pocket maximum** is the most each **covered person** must pay each **calendar year** for **deductible** and **coinsurance** for **covered expenses** other than **prescription drugs**. The family **out-of-pocket maximum** is the most each **covered employee** and his covered **dependents** combined must pay each **calendar year** for **deductibles** and **coinsurance** for **covered expenses** other than **prescription drugs**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Specialty drug**

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

″Autism Spectrum Disorders″ ″Behavioral Health Treatment″ including ″Applied Behavior Analysis″	Coverage for ″behavioral health treatment″ including ″applied behavior analysis″ not otherwise covered by the **policy** for **covered persons** diagnosed with ″autism spectrum disorders″ through age 18 is limited to a maximum annual **benefit** of $50,000 through age 6; $40,000 ages 7 through 12; and $30,000 ages 13 through 18.
Home health care services	Coverage limited to 100 visits per **calendar year** for **network** and **non-network providers** combined.
Manipulative therapy	Maximum of 26 visits for **manipulative therapy** and related services are payable in any **calendar year**.
Mental illness and **chemical dependency** services	For **mental illness** and **chemical dependency** services combined, maximum **benefit** of $4,500 per **calendar year** for **outpatient** services and $50,000 per **calendar year** for **inpatient** and **transitional treatment** combined. **Lifetime maximum** of $100,000 for all **mental illness** and **chemical dependency** services. If the **employe**r has more than 50 **employees** these sublimits do not apply. These sublimits do not apply to **serious mental illness** or **biologically based mental illness**.
Nursing facility charges	Maximum of 60 days per confinement with a total of 60 days per **illness or injury**.
Prescription Drugs	Maximum dispensing limits have been set on some **prescription drugs**. Consult your pharmacy for details. If a **generic drug** or **performance drug** does not exist or a **physician** prescribes a **brand name drug** when **medically necessary**, the **brand name drug copayment** will apply. If the **covered person** requests a **brand name drug** when a **generic drug** is available, he will pay the **brand name drug copaymen**t plus the difference in cost between the **brand name drug** and the **generic drug**. **Specialty drugs** obtained from sources other than the **specialty drug network provider** are subject to **non-network specialty drug copayments** plus the amount charged in excess of the **network** cost of the drug. **Specialty drugs** obtained as an **inpatient**, from a **physician** or from a **hospital** are subject to **non-network specialty drug copayments** plus the amount charged in excess of the **network** cost of the drug not **deductible** and **coinsurance** like other drugs received from these sources. The cost of **prescription drugs** in excess of the **network** cost of the drugs are not **covered expenses**. Some **prescription drugs** require prior authorization to be covered. Consult your pharmacy for details.

5. **Benefits** for **covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	**Network Provider**	**Non-Network Provider**
All **covered services** not listed below	**Deductible** **Coinsurance**	**Deductible** **Coinsurance**
Physician office visit charge	**Copayment** of $30	**Deductible** **Coinsurance**
Emergency care services	**Copayment** of $200 then **Coinsurance**	**Deductible** **Coinsurance** For an **emergency condition**, the **network provider copayment** and **coinsurance** apply.
	Emergency care services **copayment** is waived if the **covered person** is admitted to a **hospital** within 24 hours of the **emergency care visit**.	
Preventive care services	Services paid at 100%	**Deductible** **Coinsurance**
Annual physical	**Benefit** limited to $500 per **calendar year**.	**Deductible** **Coinsurance** **Benefit** limited to $250 per **calendar year**.
Maternity Services	**Copayment** of $30 for **office visits** **Deductible** **Coinsurance** for all other services	**Deductible** **Coinsurance**
Generic drugs	**Copayment** of $10 / 31 day supply	**Copayment** of $10 / 31 day supply plus the amount charged in excess of the **network** cost of the drug.
Performance Drugs	**Copayment** of $35 / 31 day supply	**Copayment** of $35 / 31 day supply plus the amount charged in excess of the **network** cost of the drug.
Brand name drugs	**Copayment** of $50 / 31 day supply	**Copayment** of $50 / 31 day supply plus the amount charged in excess of the **network** cost of the drug.
Specialty drugs	**Copayment** of $100 / 31 day supply	**Copayment** of $100 / 31 day supply plus the amount charged in excess of the **network** cost of the drug.
Generic drugs - mail order	**Copayment** of $20 / 90 day supply	Not available
Performance drugs - mail order	**Copayment** of $70 / 90 day supply	Not available
Brand name drugs - mail order	**Copayment** of $110 / 90 day supply	Not available
Prescription drugs, other than **specialty drugs**, received as an **inpatient** or from a **hospital** or from a **physician's** office	**Deductible** **Coinsurance**	**Deductible** **Coinsurance**

SECTION I - GENERAL PROVISIONS

Various provisions in this document restrict coverage. Read the entire document carefully to determine rights, duties and what is and is not covered.

The words "**we**", "**us**" and "**our**" refer to Federated Mutual Insurance Company.

The word "**policyholder**" means the **organization** or **employer** listed as such on the face page.

Other words and phrases appearing in **bold type** have special meaning. Refer to Section VIII - Definitions.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

1. BENEFITS

   We agree to pay **benefits** as provided in the **policy** to **covered persons**.

2. POLICY CHANGES

   Changes may be made in the **policy** only by **us** acting through **our** President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the **policy**.

3. ENTIRE CONTRACT

   The entire contract will be made up of the **policy**, the application of the **policyholder**, the applications of the **employers** and the applications of **covered persons**. All references to statements, applications, writings, and signatures as they apply to the terms of the **policy** will include their representations in electronic form, as agreed to by both **us** and the **covered person**, **employer**, or **policyholder** who made the statement, application, writing or signature.

4. INSURANCE DATA

   The **employer** will give **us** all of the data that **we** need to calculate the premium and all other information that **we** may reasonably require. **We** have the right to examine the **employer's** records relative to the **policy** at any reasonable time while the **policy** is in effect. **We** also have this right until all rights and obligations under the **policy** are finally determined.

5. STATEMENTS NOT WARRANTIES

   All statements made by the **policyholder** or **employer** or **covered person** will, in the absence of fraud, be deemed representations and not warranties. No statement made by the **policyholder** or **employer** or **covered person** to obtain coverage will be used to avoid or reduce the coverage unless it is made in writing and is signed by the **policyholder** or **employer** or **covered person** and a copy is sent to the **policyholder** or **employer** or **covered person** or his **beneficiary**.

6. MISSTATEMENT

   If information in the application of a **covered person** has been misstated, the corrected age and facts will be used to determine whether insurance is in force under the **policy** and in what amount. If insurance remains in force an equitable adjustment of premium may be made.

7. RIGHT TO CONTEST

   We have no right to contest the coverage of an **employer** on the basis of any statement made in the **employer's** application after the **employer's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **employer** and a copy of it is given to the **employer**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **employer** in his application. Nothing in this provision shall keep us from using at any time a defense based on policy provisions that relate to eligibility for coverage.

We have no right to contest the coverage of a **covered person** on the basis of any statement made in a **covered person's** application after the **covered person's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **covered person** and a copy of it is given to the **covered person** or his **beneficiary**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **covered person** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

8. TO WHOM PAYABLE

   All **benefits** are payable to the **covered person**. Except as otherwise required by applicable law, no amount payable at any time shall be subject in any manner to assignment by the **covered person**. However, at **our** option all or any part of the **benefits** may be paid directly to the **provider** on whose charge the claim is based.

   If any person to whom **benefits** are payable is a minor or, in **our** opinion, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian. However, if his legal guardian has made no request for payment, **we** may, at **our** option, make payment to the **provider**.

   If a **covered person** dies while **benefits** remain unpaid, **we** may choose to make direct payment to the **covered person's beneficiary**.

   Payment in the manner described above will release **us** from all liability to the extent of any payment made.

9. TIMING OF BENEFIT PAYMENTS

   Benefits are payable within 30 calendar days of the date **we** receive a clean claim. If additional information is needed to process a claim, a request will be sent to the **provider** or **covered person** within 30 calendar days.

   A "clean claim" is one where no additional documentation or information is needed to determine eligibility or process the claim. "Clean claim" does not include claims for services during times when premium is not paid or where fraud is suspected.

   We reserve the right to review and audit **provider** billings and records by providing notice of **our** intent to review or audit to the **provider** within 180 days of the **benefit** payment.

10. LEGAL ACTIONS

    No action at law or in equity will be brought to recover on the **policy** until at least 60 days after completion of all appeals as outlined in Section IX - **Grievance** and Appeal Procedure. No action will be brought at all unless brought within 3 years after the time within which the appeals are complete.

11. PHYSICIAN / PATIENT RELATIONSHIP

    The **covered person** will have the right to choose any **physician** who is practicing legally. **We** will in no way disturb the **physician** / patient relationship.

    Covered expenses for **covered services** (except preventive care) are payable whether provided by a **network provider** or **non-network provider**. The only difference is the **copayment, coinsurance, deductible** and **out-of-pocket maximum** listed in the **schedule**.

12. CERTIFICATES

    At **our** option, **we** will issue to the **employer** for delivery to each **covered employee** an individual certificate or **we** will deliver to each **covered employee** an individual certificate. The certificate will show the **benefits** provided under the **policy** and to whom **benefits** will be paid. Nothing in the certificate will change or void the terms of the **policy**.

13. SEVERABILITY

    Any provision of the **policy** that is prohibited by law shall be void and be without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the **policy**.

14. SUBROGATION

To the extent allowed by law, when **we** have provided **benefits** to or on behalf of a **covered person** due to an **illness or injury, we** will have subrogation and/or reimbursement rights. If a **covered person** recovers damages from a third party that is liable for the **illness or injury**, the **covered person** will reimburse **us** for amounts **we** have paid as **benefits** for that **illness or injury**. If a **covered person** recovers damages for the **illness or injury** from any other insurance, the **covered person** will reimburse **us** for amounts **we** have paid as **benefits** for that **illness or injury**.

The **covered person** will not prejudice **our** right to recover from a liable third party. Entering into a settlement or compromise arrangement without **our** prior consent will be deemed to prejudice **our** rights. A **covered person** must notify **us** anytime he has a claim against a third party for medical treatment, services or supplies for which **we** have paid **benefits**.

This subrogation provision will apply to any settlement or judgment received by the **covered person**. **We** are entitled to full recovery of **benefits we** paid even if:

a. The third party does not admit liability; or

b. The settlement or judgment does not identify any amounts paid as medical expenses.

We are not required to participate in any legal action by the **covered person** to recover damages. **We** are not required to pay any fees or costs incurred by the **covered person** or his attorney to recover damages.

15. PREMIUMS

a. PREMIUM PAYMENT. The premium for each **covered person** will be due prior to the first day of each **month**. All premiums are payable in advance by the **employer** at **our** Home Office or to **our** designated premium collection agent. All premiums must be made payable to "Federated Mutual Insurance Company." **Our** insurance agents are not authorized to collect premiums other than the first premium.

b. MONTHLY PREMIUM STATEMENT. A monthly premium statement will be prepared prior to the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of **covered persons** and changes in coverage that took place in the preceding **month**.

c. CHANGES IN PREMIUM RATES. **We** may change any premium rate from time to time with at least 31 days advance written notice. No change in rates will be made until 12 **months** after the date an **employer** purchases the **policy**.

However, **we** may change rates immediately only if, in **our** opinion, **our** liability is altered:

i. by any change in state or federal law; or

ii. by a revision in the insurance under the **policy** including but not limited to changes of over 20% in the number of **covered persons** with any one **employer**.

Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If any increase in rates takes place on a date that is not a premium due date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next premium due date. If a decrease in rates takes place on a date that is not a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

d. GRACE PERIOD. If, before a premium due date, the **employer** has not given written notice to **us** that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to **us** for any unpaid premium for the time the coverage was in force including the grace period.

e. INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has terminated, will be refunded without interest when requested by the **employer**. These premiums will not be refunded for more than the **month** in which **we** are notified of the termination of coverage.

f. NON- PARTICIPATING PREMIUM REFUNDS. The **policy** does not share in **our** surplus earnings.

16. PRE-CERTIFICATION REQUIREMENTS

a. PRE-CERTIFICATION PROCESS

Pre-certification refers to the process used to certify the **medical necessity** and length or type of any **admission**, treatment, service or supply required to be pre-certified in Section VI - Covered Services. Pre-certification is done through a review organization. The review organization is an organization with a staff of medical professionals that performs the review and is accredited by URAC/American Accreditation HealthCare Commission. The name and phone number of the review organization is on the identification card provided to **covered persons**. The review organization will determine if the **admission**, treatment, service or supply is pre-certified. **We** determine the **benefits** that will be payable under the **policy**. Pre-certification does not guarantee that **benefits** are payable under the **policy**. **Benefits** will be determined when a claim for **covered expenses** is received by **us**.

i. **Inpatient** treatment pre-certification

If a **physician** recommends that a **covered person** be admitted for **inpatient** treatment in a non-emergency situation, it is the **covered person's** responsibility to make sure that **our** review organization is notified of the proposed **admission**. This notice must be given no more than thirty business days before the proposed **admission** date, but at least five business days before the proposed **admission** date.

For an emergency **admission**, it is the **covered person's** responsibility to make sure a request to certify is made as soon as possible but not more than 48 hours after **admission**.

It is the **covered person's** responsibility to make sure a request to pre-certify is made prior to the end of the certified length of stay for continued **inpatient** confinement.

ii. **Outpatient** treatment pre-certification

If a **physician** recommends a treatment, service or supply that Section VI - Covered Services requires to be pre-certified, it is the **covered person's** responsibility to make sure that **our** review organization is notified at least five business days before the proposed treatment, service or supply is received. The five business day requirement will be waived if the treatment, service or supply is required for an **emergency condition**.

It is the **covered person's** responsibility to make sure a request to pre-certify is made prior to receiving additional treatment, services or supplies required to be pre-certified.

iii. Notification requirements and review process

The notification must be made in writing or by telephone to the review organization and must include:

(1) **Covered person** and **employee** information: name, birth date, social security number, file/group number, telephone number and address; and

(2) **Physician** information: name, telephone number, address and medical specialty; and

(3) Facility information: name, address and telephone number of the facility to which the **covered person** will be admitted or where he will receive the treatment, service or supply; and

(4) Medical information: the proposed **admission** or treatment date; the reason for **admission**, treatment, service or supply; the proposed length or type of **admission**, treatment service or supply.

Our review organization may contact the **physician's** office to obtain additional information about the proposed **admission**, treatment, service or supply. The proposed **admission**, treatment, service or supply may be reviewed in consultation with the **physician** (provided the **physician** is available for such consultation). If the request to pre-certify is received at least five business days before the date of the proposed **admission**, treatment, service, or supply is to be done, **our** review organization will notify the **covered person** and **providers** of the decision at least 24 hours in advance of the date of the proposed **admission**, treatment, service or supply. Pre-certification is not a guarantee of coverage under the **policy**.

If the **physician's** office fails to provide the information needed or the request to pre-certify is not received five business days in advance, the review organization may not be able to complete the review. In such case, the **admission**, treatment, service or supply cannot be pre-certified. The review organization may also determine that the proposed **admission**, treatment, service or supply is not **medically necessary** for the **covered person**.

b. PRE-CERTIFICATION PENALTIES

If a **covered person** does not have his **inpatient** confinement or **outpatient** treatment, service or supply pre-certified when required, it will result in a reduction of **benefits**.

i. For an **inpatient** confinement, **covered expenses** will not include any days that were not pre-certified.

ii. For **covered services** other than **inpatient** confinement, **covered expenses** will not include any treatment, service or supply that was not pre-certified.

If it is later determined that the **inpatient** confinement or **outpatient** treatment, service or supply that was not pre-certified as required was **medically necessary** a penalty will be applied to the amount determined to be **covered expense** for each **inpatient** confinement or **outpatient** treatment, service or supply. The penalty will be 50% of the amount of **covered expenses** not to exceed $500 for each charged **covered service** not pre-certified as required.

Expenses incurred by a **covered person** that are not payable because they were not pre-certified and penalties for failure to pre-certify are not applied to the **deductible** or any **out-of-pocket maximum**.

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. **EMPLOYER** ENROLLMENT AND EFFECTIVE DATE

   a. An **employer** shall apply to become a **policyholder**. The **employer** will become a **policyholder** on the first day of the **month** coinciding with or following the date such **employer** applies subject to:

      i. approval by **us**; and

      ii. meeting the participation requirements shown below; and

      iii. meeting the contribution requirements shown below.

   b. Once an **employer** becomes a **policyholder** they can make changes to the policy chosen either:

      i. prior to the anniversary of their original effective date to be effective on the anniversary of their original effective date; or

      ii. prior to 12:01 am Central Standard Time on December 15 any **calendar year** to be effective on the first day of January.

2. PARTICIPATION REQUIREMENTS

   a. If the **employer** has 10 or fewer **employees**, 100% of the eligible **employees** seeking health care coverage through the **employer** must be enrolled for coverage at all times.

   b. If the **employer** has 11 to 25 **employees,** 75% of the eligible **employees** seeking health care coverage through the **employer** must be enrolled for coverage at all times.

   c. If the **employer** has 26 to 50 **employees**, 50% of all eligible **employees** seeking health care coverage through the **employer** must be enrolled for coverage at all times.

   d. If the **employer** has 51 or more **employees,** 85% of the eligible **employees** and **dependents** not covered under a separate employer's plan must be enrolled for coverage at all times. If the **employer** is paying 100% of the premium, all eligible **employees** and **dependents** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   If the **employer** has 51 or more **employees** and the **employer** does not pay the full premium for **covered employees** and **dependents**, the **employer** must:

   a. pay a minimum of 70% of the premium for **covered employees**; or

   b. pay a minimum of 35% of the total premium for **covered employees** and **dependents**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible to enroll for coverage under the **policy** if he is **actively at work** or absent from work due to a **health status related factor** and:

      i. has completed the **waiting period** shown in the **employer's** application for coverage; or

      ii. was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with **us**.

   b. An **employee** is only eligible for **dependent** coverage if he elects **employee** coverage.

   c. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **DEPENDENT** ELIGIBILITY

   a. **Dependents** are eligible to enroll for coverage under the **policy** if:

      i. they meet the definition of a **dependent** in Section VIII - Definitions; and

ii. the **employee** is covered under the **policy**; and

iii. the additional premium for **dependent** coverage is paid.

b. Once enrolled, a **dependent** is eligible for coverage under the **policy** only if he meets the definition of a **dependent** in Section VIII - Definitions.

6. OPEN ENROLLMENT PERIOD

The "open enrollment period" will be from 12:01 am Central Standard Time on October 1 through 12:01 am Central Standard Time on December 15 each **calendar year**. Coverage for an **employee** or **dependent** that enrolls during the "open enrollment period" will be effective on the first day of January following their enrollment.

7. **EMPLOYEE** EFFECTIVE DATE

Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

a. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

b. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

c. If not elected within 31 days after he becomes eligible, an **employee** can only enroll for coverage during the "open enrollment period" established by **us** or according to the special enrollment provisions in item 11 below. If an **employee** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

8. **DEPENDENT** EFFECTIVE DATE (other than newborn or adopted children)

Each **covered employee** may elect **dependent** coverage by completing and signing an application. The effective date of coverage for each **dependent**, except newborn or adopted children, depends upon the date on which the **employee** elects coverage for that **dependent**. If a **dependent** is no longer covered because his eligibility ended, he must re-enroll for coverage if he becomes eligible again. Coverage is not automatically reinstated for **dependents** that were previously covered.

Coverage for a newborn or adopted child is effective as outlined in subparts 9 &10 below.

a. If elected on or before the date the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after the **employee** becomes eligible.

b. If elected within 31 days after the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after election.

c. If not elected within 31 days after the **employee** becomes eligible, each **dependent** can only enroll for coverage during the "open enrollment period" established by **us** or according to the special enrollment provisions in item 11 below. If a **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

d. If the **employee** acquires an additional **dependent** the effective date of coverage will be according to the special enrollment provisions in item 11 below.

9. NEWBORN'S EFFECTIVE DATE

The effective date of coverage for a newborn **dependent** child who is born while an **employee** is a **covered employee** will be as follows:

a. Coverage will be in effect from the moment of birth for 31 days for a newborn child who would qualify as a **dependent**. In order for coverage to continue beyond 31 days, within those 31 days the **covered employee** must:

i. notify **us** of the birth of a child; and

ii. pay any required premium for coverage of the child as a **dependent**

b. If the **covered employee** does not provide notice and pay any required premium within 31 days of the birth of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If a newborn **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

10. ADOPTED CHILD EFFECTIVE DATE

The effective date for a **dependent** child who is adopted by an **employee** while he is a **covered employee** will be as follows:

a. Coverage will be in effect from the date of the "placement for adoption" if within 31 days of the "placement for adoption" of a child who would qualify as a **dependent,** the **covered employee**:

i. notifies **us** of the "placement for adoption" of the child; and

ii. **we** receive payment of any required premium for coverage of the child as a **dependent**.

b. If the **covered employee** does not provide notice and pay any required premium within 31 days of the "placement for adoption" of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If an adopted **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

The term "Placement for Adoption" means the earlier of:

i. the date of placement of the child with the **covered employee** for purposes of adoption;

ii. the date of entry of an order granting the **covered employee** custody of the child for purposes of adoption; or

iii. the effective date of the adoption by the **covered employee**.

The child's placement with the **covered employee** terminates if prior to legal adoption the child is removed from the placement.

11. SPECIAL ENROLLMENT PROVISIONS

a. For Individuals Losing Other Coverage

An **employee** and any eligible **dependents** who are otherwise eligible under the **policy**; and failed to enroll when first eligible may enroll for coverage outside the "open enrollment period", but only if each of the following conditions are met:

i. the **employee** and/or any eligible **dependents** were covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO policy) at the time coverage under the **policy** was first offered; and

ii. the **employee** stated in writing that coverage under such group health plan or health insurance coverage was the reason for declining enrollment; but only if **we** required such a statement and provided the **employee** with notice of such requirement (and the consequences of such requirement) at such time; and

iii. if such coverage:

(1) was under a **COBRA** continuation provision and the coverage under such provision was exhausted; or

(2) was not under a **COBRA** continuation provision and the coverage was terminated as a result of either:

(a) legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment; or

(b) the current or former employer contributions toward such coverage terminating; and

iv. the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** not later than 30 days after the date such other coverage ended. The coverage will become effective on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date, as agreed to by **us**.

b. For Individuals Otherwise Eligible

In addition to the eligibility provisions contained in the **policy**, the following also applies:

i. If the **employee** is covered under the **policy** (or has met any **waiting period** and is eligible to enroll under the **policy**, but did not enroll during a previous enrollment period); and a person becomes an eligible **dependent** through marriage, birth, adoption or placement for adoption; **we** will provide:

(1) a special enrollment period described below during which such **dependent** may be enrolled under the **policy**;

(2) in the case of the birth or adoption of a child, a special enrollment period for the **employee's spouse** to enroll as a **dependent** if otherwise eligible for coverage.

The **employee** must be eligible for coverage and enrolled under the **policy** for coverage to be effective for the **employee's dependent**. If the **employee** is not enrolled, the **employee** may enroll at the same time as the **dependent** during this special enrollment period.

ii. The special enrollment period will be a period of 30 days, and begins on the later of:

(1) the date **dependent** coverage is made available under the **policy**; or

(2) the date of the marriage, birth, adoption or placement for adoption.

iii. If the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** during the 30 days of such special enrollment period, the coverage will be effective:

(1) in the case of marriage, on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date as agreed to by **us**;

(2) in the case of a **dependent's** birth, on the date of such birth; or

(3) in the case of a **dependent's** adoption or placement for adoption, the date of such adoption or placement for adoption.

SECTION III - TERMINATION OF COVERAGE

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions. See Section IV - Extension of Coverage, Continuation of Coverage & Conversion for information on eligibility and options for coverage after termination.

1. The **employer's** coverage under the **policy** will terminate at the earliest of the following dates:
   a. the date the **employer** fails to make any premium payment when due;
   b. the date the **employer** fails to comply with the **employer** contribution rules;
   c. the date participation requirements are no longer met;
   d. the date the **employer** commits fraud or intentionally misrepresents a material fact;
   e. for **policies** that utilize a health provider network, the date there is no longer any **covered person** who lives, resides or works in the network service area;
   f. for association groups, the date the membership of an **employer** in the association ceases; or
   g. the date **we** elect to discontinue the **policy** as permitted by state and federal law.
2. An **employee's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions; or
   d. the date the **policy** terminates.
3. A **dependent's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions;
   d. the date the premium is not paid for **dependent** coverage;
   e. the date the **policy** terminates; or
   f. the date the **dependent** no longer meets the definition of **dependent** in Section VIII - Definitions. However, the **covered employee** may elect to continue coverage for a **dependent** child until the end of the **calendar year** in which the **dependent** child attains the age of 26.
4. If a **dependent's** coverage would terminate because the **covered employee** dies, the **dependent** can continue coverage, if premiums are paid, until the earliest of the following dates:
   a. the last day of the third (3) **month** after the **employee's** death;
   b. the date of the remarriage of a surviving **spouse**;
   c. the date he no longer qualifies as a **dependent** under the **policy**;
   d. the date the **dependent** becomes covered under other group health care coverage;
   e. the date the **employer's** coverage terminates;
   f. the date the premium is not paid for **dependent** coverage; or
   g. the date the **policy** terminates.

5. The **employer** has the right to terminate coverage by providing **us** with advance written notice of his intent. The notice must be sent to **us** at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060

   Coverage will terminate on the last day of the **month** in which **we** receive the **employer's** written notice of intent to terminate.

6. An **employee** or covered **dependent** has the right to terminate coverage by providing his **employer** with advance written notice of his intent. The **employer** must then notify **us** at the following address.

   Group Administration
   Federated Mutual Insurance Company
   PO Box 328
   Owatonna, MN 55060
   or by calling 800-377-9154.

   An **employee's** or covered **dependent's** coverage will terminate on the last day of the **month** in which **we** receive the **employer's** notice of intent to terminate coverage for that **employee** or covered **dependent**.

7. GRACE PERIOD

   If, before a premium due date, the **employer** has not given written notice to **us** that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to us for any unpaid premium for the time the coverage was in force including the grace period.

SECTION IV - EXTENSION OF COVERAGE, CONTINUATION OF COVERAGE & CONVERSION

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. EXTENSION OF COVERAGE - TEMPORARY LAYOFF OR LEAVE OF ABSENCE

   If an **employee** is no longer **actively at work** due to a layoff or leave of absence, then coverage will be extended for **covered persons** for four (4) months if the **employer** continues to pay the premium.

   Leave of absence includes **employees** who are not **actively at work** due to an **illness or injury**.

2. EXTENSION OF COVERAGE - DISABILITY

   a. If an **employee** or **dependent** is:

      i. **disabled** on the date his coverage terminates; and

      ii. not covered by any other group type **plan** for medical expense or eligible for **Medicare**;

      then the **policy** will extend coverage for three (3) **months** for **covered services** related to the disabling condition if the **employee** or **dependent** remains continuously **disabled**. No premium is due for this extension of coverage.

   b. This extension does not apply to:

      i. expenses not related to the disabling condition;

      ii. an **employee** and/or **dependent** when he is covered under another group type plan for medical expense or eligible for **Medicare**; or

      iii. children born after the **employee's** or **dependent's** coverage terminates.

3. CONTINUATION

   Coverage may be continued for an **employee** and his covered **dependents** after the date it would end due to termination of the **employee's** employment or the reduction of the **employee's** working hours so that he no longer qualifies as **actively at work**. Coverage may also be continued for covered **dependents** whose coverage terminates as a result of divorce or death of the **employee** or the **employee's** termination of coverage due to the **employee's** enrollment in **Medicare**. This continuation is subject to the following provisions:

   a. The **covered person** must have been insured under the **policy** during the entire 3-**month** period before insurance terminates.

   b. Continuation of coverage is not available:

      i. if the **covered person** is eligible for **Medicare**; or

      ii. if the **covered person** is eligible for coverage under other group health care coverage and was not covered under such coverage immediately prior to the date his coverage terminated.

   c. The **employer** must give a terminated **employee** written notice of his right to continue coverage within ten days after the date his coverage would otherwise terminate. The **employee** must pay premiums at the current monthly rates for coverage. These premiums must be paid to the **employer** on or before the 31st day after the day his insurance would otherwise have terminated and on the same date of each **month** thereafter.

      To continue coverage, a **dependent** whose coverage terminates as a result of divorce or death of the **employee** must notify the **employer** in writing of his intention to continue coverage within 31 days of the date of divorce or death. Within ten days of receipt of such notice from a **dependent**, the **employer** must give the **dependent** written notice of his rights to continue coverage. The **dependent** must pay premiums at the current monthly rates of coverage. These premiums must be paid to the **employer** not later than ten days after receiving notice of his continuation right from the **employer**.

d. This continuation of coverage will automatically stop at the earliest of the following dates:

i. the date the **policy** is terminated;

ii. the date coverage is terminated for the **employee's employer**;

iii. the date coverage would have terminated in the absence of these continuation provisions, if any required premium payment is not made by the **covered person**;

iv. the date the **covered person** becomes eligible for coverage under other group health care coverage or becomes eligible for **Medicare**;

v. the end of a 3-**month** period commencing on the date on which such insurance would have terminated in the absence of these continuation provisions;

vi. for **dependents**, the date on which the **dependent** ceases to be eligible for coverage under the **policy**;

vii. for a **dependent** whose coverage is being continued because of divorce, the date on which the **employee** ceases to be eligible for coverage under the **policy**; or

viii. the date of remarriage of the **employee's** former **spouse**.

e. This continuation runs concurrently with any other continuation available to the **employee** or **dependent** under the **policy**.

4. **COBRA** CONTINUATION (applies only if the **employer** has 20 or more **employees**, including part-time **employees**, normally employed on a typical business day during the prior **calendar year**).

Coverage may be continued beyond the date it would terminate, subject to the following provisions:

a. Continuation is available to any **covered person** whose coverage would otherwise terminate due to any of the following qualifying events:

i. the death of the **employee**;

ii. the termination (other than by reasons of gross misconduct) of the **employee's** employment, or the reduction of the **employee's** working hours so that he no longer qualifies as **actively at work**;

iii. the divorce or legal separation of the **employee** from his or her **spouse**;

iv. the **employee** becoming entitled to **Medicare**; or

v. a **dependent** child ceasing to be a **dependent** as defined in the **policy**.

b. The **employee** or **dependent** must notify the **employer** of any change in family status (divorce, separation or ineligibility of a child).

c. In order to continue coverage, election must be made within 60 days after the later of:

i. the date the **employer** notifies the **covered person** of his or her continuation right; or

ii. the date coverage would terminate.

In addition, the first premium payment must be made within 45 days of the election to continue coverage. Thereafter, premiums are due to advance and must be received within 30 days of the due date.

d. Coverage may be continued for:

i. 18 **months** in the case of termination of employment or reduction in hours (29 **months** if the Social Security Administration determines that a **covered person** was disabled at any time during prior to the 60th day of the continuation coverage and the **covered person** notifies the **employer** within 60 days of the Social Security Administration's disability determination and before the end of the 18-**month** continuation coverage);

ii. 36 **months** from the date of any other qualifying event noted in 4.a. above, and if more than 1 qualifying event occurs to a **dependent**, the maximum length of continuation available is 36 **months** from the date of the first qualifying event. Except, if an **employee** terminates employment after becoming entitled to **Medicare**, then coverage for a **dependent** may be continued for 18 **months** from the date of termination of employment or 36 **months** from the date of **Medicare** entitlement, whichever is the longer time period.

e. The continuation for a **covered person** will automatically terminate at the earliest of the following dates:

i. the date the **policy** is terminated;

ii. the date coverage is terminated for the **employee's employer**;

iii. the date coverage would have terminated in the absence of these continuation provisions, if any required premium payment is not made by such **covered person** as provided in 4.c. above;

iv. the date a **covered person** becomes covered under another group health plan that does not contain a pre-existing condition limitation for that person;

v. the date a **covered person** becomes entitled to **Medicare**; or

vi. the date it is determined a **covered person** whose continuation coverage has been extended due to a Social Security Administration disability determination is no longer disabled.

f. This continuation runs concurrently with any other continuation available to the **employee** or **dependent** under the **policy**.

5. CONVERSION PRIVILEGE

a. When a **covered person's** coverage terminates, he may be eligible to be insured under an individual policy of medical care benefits (called the "Converted Policy"). A "Converted Policy" will be issued by **us** only to a person who is entitled to convert, and only if he applies in writing and pays the first premium for the "Converted Policy" to **us** within 31 days after the date his insurance terminates. The "Converted Policy" will take effect on the date his coverage terminates. Proof of good health is not needed.

b. **EMPLOYEES** ENTITLED TO CONVERT. An **employee** is entitled to convert coverage for himself and all of his **dependents** who were insured when his insurance terminated, but only if:

i. the **employee's** insurance terminated because he was no longer **actively at work**; and

ii. the **employee** is not eligible for **Medicare**; and

iii. the **employee** would not be overinsured.

c. DEPENDENTS ENTITLED TO CONVERT. The following **dependents** are also entitled to convert:

i. a child whose coverage under this plan terminates because he no longer qualifies as a **dependent** or because of the **employee's** death;

ii. a **spouse** whose coverage under the plan terminates due to divorce, legal separation, or because of the **employee's** death; or

iii. the **dependents** of an **employee**, if the **employee** is not entitled to convert solely because he is eligible for **Medicare**;

But only if that **dependent**:

i. was covered when the **employee's** insurance terminated;

ii. is not eligible for **Medicare**; and

iii. would not be overinsured.

d. OVERINSURED. A person will be considered overinsured if:

i. his insurance under the **policy** is replaced by similar group coverage within 31 days; or

ii. the coverage under the "Converted Policy", combined with similar coverage, result in an excess of insurance based on **our** underwriting standards for individual policies. Similar coverage is:

(1) that for which the person is covered by another hospital, surgical or medical expense insurance policy; or a hospital or medical service subscriber contract; or a medical practice or other prepayment plan or by any other plan or program;

(2) that for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or

(3) that available for the person by or through any state, provincial or federal law.

e. CONVERTED POLICY. **We** will give the **employee** or **dependent**, on request, further details of the "Converted Policy".

SECTION V - COORDINATION OF BENEFITS & **MEDICARE** INTEGRATION

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. This coordination of benefits (**COB**) provision applies when a **covered person** has health care coverage under more than one **plan**. This **COB** provision does not apply when the **covered person** has health care coverage under only this **plan** and **Medicare**. In that situation **benefits** are integrated with **Medicare** coverage under section 7 below.

   When a **covered person** is covered by two or more **plans**, the rules for determining the order of payment are as follows:

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

   b. Except as provided in section 1.c. below, a **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both **plans** state that the complying **plan** is primary.

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

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

2. ORDER OF **BENEFIT** DETERMINATION RULES

   Each **plan** determines its order of **benefits** using the first of the following rules that apply:

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

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

      i. For a **dependent** child whose parents are married or are living together, whether or not they have ever been married:

         (1) the **plan** of the parent whose birthday falls earlier in the **calendar year** is the primary **plan**; or

         (2) if both parents have the same birthday, the **plan** that has covered the parent the longest is the primary **plan**.

      ii. For a **dependent** child whose parents are divorced or separated or not living together, whether or not they have ever been married:

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

         (2) if a court decree states that both parents are responsible for the **dependent** child's health care expenses or health care coverage, the provisions of section 2.b.i. above shall determine the order of **benefits**;

         (3) if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the **dependent** child, the provisions of section 2.b.i. above shall determine the order of **benefits**; or

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

(a) the **plan** of the **custodial parent**;

(b) the **plan** covering the spouse of the **custodial parent**;

(c) the **plan** of the noncustodial parent; and then

(d) the **plan** covering the **spouse** of the noncustodial parent.

iii. For a **dependent** child covered under more than one **plan** of individuals who are not the parents of the child, the provisions of section 2.b.i. or section 2.b.ii. above shall determine the order of benefits as if those individual were the parents of the child.

c. Active employee or retired or laid-off employee. The **plan** that covers a person as an employee, that is, an employee who is neither laid off nor retired, is the primary **plan**. The **plan** covering the same person as a retired or laid-off employee is the secondary **plan**. The same would hold true if a person is a **dependent** of an active employee and that same person is a **dependent** of a retired or laid-off employee. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of **benefits**, this rule is ignored. This rule does not apply if section 2.a. above can determine the order of **benefits**.

d. **COBRA** or State Continuation coverage. If a person whose coverage is provided pursuant to **COBRA** or under a right of continuation provided by state or other federal law is covered under another **plan**, the **plan** covering the person as an **employee**, member, subscriber or retiree or covering the person as a **dependent** of an **employee**, member, subscriber or retiree is the primary **plan** and the **COBRA** or state or other federal continuation coverage is the secondary **plan**. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of **benefits**, this rule is ignored. This rule does not apply if section 2.a. above can determine the order of **benefits**.

e. Longer or shorter length of coverage. The **plan** that covered the person as an **employee**, member, policyholder, subscriber or retiree longer is primary **plan** and the **plan** that covered the person the shorter period of time is the secondary **plan**.

f. If the preceding rules do not determine the order of **benefits**, the **allowable expenses** shall be shared equally between the **plans** meeting the definition of **plan**. In addition, this **plan** will not pay more than it would have paid had it been the primary **plan**.

3. EFFECT ON THE **BENEFITS** OF THIS **PLAN**

a. When this **plan** is secondary, **we** may reduce **our benefits** so that the total **benefits** paid or provided by all **plans** during a **plan** year are not more than the total **allowable expenses**. In determining the amount to be paid for any claim, the secondary **plan** will calculate the **benefits** it would have paid in the absence of other health care coverage and apply that calculated amount to any **allowable expense** under its **plan** that is unpaid by the primary **plan**. The second **plan** may then reduce its payment by the amount so that, when combined with the amount paid by the primary **plan**, the total **benefits** paid or provided by all **plans** for the claim do not exceed the total **allowable expense** for that claim. In addition, the secondary **plan** shall credit to its **plan** deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

4. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

5. 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 form of services, in which case "payment made" means reasonable cash value of the **benefits** provided in the form of services.

6. RIGHT OF RECOVERY

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

7. **MEDICARE** INTEGRATION

a. INTEGRATION WITH **MEDICARE** - AGE 65 AND OVER

If a **covered person** is 65 years or older and eligible for **Medicare** (whether enrolled or not) and the covered **employee's employer** is not subject to ADEA (the Age Discrimination in Employment Act) the **benefits** under the **policy** will be calculated as follows:

i. the amount paid by **Medicare** or that would have been paid by **Medicare** had the **covered person** enrolled will be determined;

ii. then the amount to be paid by **us** will be computed on the remaining **covered expense** (total **covered expense** less amount paid by **Medicare** or that would have been paid by **Medicare** had the **covered person** enrolled).

b. INTEGRATION WITH **MEDICARE** - UNDER AGE 65

i. If a **covered person** is less than 65 years of age and eligible for **Medicare** (whether enrolled or not) due to disability, other than disability due to "end stage renal disease," the **benefits** under the **policy** will be calculated as follows:

(1) the amount paid by **Medicare** or that would have been paid by **Medicare** had the **covered person** enrolled will be determined;

(2) then the amount to be paid by **us** will be computed on the remaining **covered expense** (total **covered expense** less amount paid by **Medicare** or that would have been paid by **Medicare** had the **covered person** enrolled).

ii. If a **covered person** is less than 65 years of age and eligible for **Medicare** (whether enrolled or not) due to "end stage renal disease," **benefits** under the **policy** will be calculated as follows:

(1) during the first 30 **months** the **benefits** under the **policy** will be paid before the benefits and services provided by **Medicare** are paid; and

(2) after the first 30 **months** the **benefits** under the **policy** will be payable as follows:

(a) the amount paid by **Medicare** or that would have been paid by **Medicare** had the **covered person** enrolled will be determined;

(b) then the amount to be paid by **us** will be computed on the remaining **covered expense** (total **covered expense** less amount paid by **Medicare** or that would have been paid by **Medicare** had the covered **person enrolled**).

SECTION VI - **COVERED SERVICES**

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

If a **covered person** receives **covered services**, **we** will pay **benefits** as provided in the **schedule** for **covered expenses**. Payment of **benefits** will be subject to the annual maximum and any other applicable provisions set forth in the **schedule**. The maximum amount allowed for any **covered service** is the **reasonable and customary charge** for the treatment, service or supply.

Covered expenses for **covered services** (except preventive care) are payable whether provided by a **network provider** or **non-network provider**. The only difference is the **copayment**, **coinsurance**, **deductible** and **out-of-pocket maximum** listed in the **schedule**.

The following treatments, services and supplies are **covered services** if they are **medically necessary** and ordered by a **physician** because of an **illness or injury**. If the treatment, service or supply is not listed in this section or is excluded in Section VII - Exclusions, that treatment, service or supply is not covered and **benefits** are not payable under the **policy**. That a **physician** has performed or prescribed it, or that it may be the only treatment for a particular **illness or injury** does not mean that a treatment, service or supply is a **covered service** under the **policy**.

Any **covered service** specifically listed is only covered by that specific listing and not any general listing of **covered services**.

For **covered services** listed as "pre-certification required" see Section I - General Provisions, 16. Pre-Certification Requirements.

1. AMBULANCE SERVICES

   Professional ambulance service for ground transportation to the nearest appropriate **hospital** for an **emergency condition** or the **medically necessary** transfer of a **covered person** from one **hospital** to another. Air ambulance expenses are only eligible for transportation from the site of an emergency to the nearest appropriate facility.

   For pregnancy, coverage is limited to **emergency conditions**. This does not include transportation for an uncomplicated or cesarean delivery.

2. ANESTHESIA SERVICES

   Anesthesia services related to **surgical** procedures or dental treatment or maternity services that are covered under the **policy**. When multiple **surgical** procedures are done in the same operative session **covered expenses** include the **reasonable and customary charge** for a single anesthesia service. There is no coverage for additional anesthesia services during the same operative session.

3. **CHEMICAL DEPENDENCY** SERVICES

   (Pre-Certification Required for inpatient or transitional treatment)

   See **schedule** for calendar year and **lifetime maximum** limits.

   a. **Outpatient** Services: **We** cover services for diagnosis and treatment of **chemical dependency** provided by a **physician** or a licensed professional under his **direct supervision**. A comprehensive diagnostic assessment must be the basis for a determination by a **physician** concerning the appropriate treatment and the extent of services required. The services must be furnished under a written plan established by a **physician** and regularly reviewed by the **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

   b. **Inpatient** Services: **We** cover **inpatient** services in a **hospital**, **residential treatment facility**, or **chemical dependency treatment facility** located in the **covered person's** state of residence and services by a **physician** or a licensed professional under his **direct supervision** for treatment of **chemical dependency**.

c. Transitional Treatment Arrangements: Services are covered for a transitional treatment arrangement. "Transitional treatment arrangement" means services for the treatment of **chemical dependency** that are provided to a **covered person** in a less restrictive manner than **inpatient** services but in a more intensive manner than **outpatient** services. Transitional treatment includes:

i. Certified or licensed residential treatment facility programs for chemically dependent persons located in the **covered person's** state of residence.

ii. Services for **chemical dependency** provided in a certified or licensed **day treatment** program located in the **covered person's** state of residence.

Transitional treatment does not include halfway houses or programs.

4. CONTRACEPTIVE DEVICES

Coverage is provided for contraceptive devices ordered by a **physician**. **Prescription drugs** for contraception are covered under the **prescription drug** coverage.

5. DENTAL SERVICES

Treatment, services or supplies for:

a. **surgical** removal of impacted teeth;

b. charges for dental work due to an accident, except chewing accidents, to **sound natural teeth** when the services are performed within one year from the date of the accident;

c. dental treatment provided by a **hospital** including anesthesia services; or

d. oral tumors or cysts whether by a medical doctor or oral surgeon.

Coverage is not determined by the **medical necessity** of or the underlying cause of the need for the dental care. Coverage is based on the type of service provided and the anatomical structure on which the procedure is performed.

6. DIABETES SERVICES

For **covered persons** diagnosed with diabetes:

a. Training and education through a **diabetes education program** for the self-management of all types of diabetes mellitus. The education program must be ordered by a **physician** and provided by a state-certified program.

b. The following equipment and supplies are covered as **medical supplies**:

i. injection aids;

ii. insulin measurement and administration aids for the visually impaired; and

iii. biohazard disposal containers.

c. The following equipment and supplies are covered as **durable medical equipment**:

i. blood glucose monitors;

ii. blood glucose monitors for the legally blind;

iii. insulin pumps and all supplies for the pump;

iv. insulin infusion devices; and

v. other medical devices for treatment of diabetes.

d. The following equipment and supplies are covered as **prescription drugs**:

i. test strips for glucose monitors;

ii. urine testing strips;

iii. insulin;

iv. lancets and lancet devices;

v. syringes;

vi. prescribed oral agents for controlling blood sugars;

vii. glucose agents; and

viii. glucagon kits.

7. DIAGNOSTIC SERVICES - RADIOLOGY, PATHOLOGY, LABORATORY AND OTHER DIAGNOSTIC SERVICES

(Pre-Certification Required; see **schedule** for tests requiring pre-certification)

Radiology, pathology, laboratory, and other diagnostic tests for the treatment and diagnosis of **illness or injury**.

8. DIALYSIS SERVICES

Treatment, services or supplies at the dialysis unit of a **hospital** or at a dialysis facility.

9. **DURABLE MEDICAL EQUIPMENT**

(Pre-Certification Required)

The purchase, fitting, necessary adjustments, repairs, and replacements due to normal wear and tear of **durable medical equipment**.

Coverage for **durable medical equipment** will be limited to the standard models as determined by **us**. The **covered person** is responsible for paying any amount in excess of the charge for the standard model. **Covered services** include subsequent repairs necessary to restore the most recently purchased **durable medical equipment** to a serviceable condition. Repairs due to abuse or misuse, as determined by **us**, of the **durable medical equipment** are not covered.

Covered services include the replacement of **durable medical equipment** that has been outgrown due to normal skeletal growth. **Covered services** include the replacement of **durable medical equipment** due to wear and tear, but only after the **covered person** has had the **durable medical equipment** for at least five years and only on a five-year replacement basis thereafter.

It is **our** option to pay for either the rental or purchase of **durable medical equipment**. Total rental charges will be limited to the purchase price of the **durable medical equipment**.

Batteries for **durable medical equipment** are only covered as part of the initial purchase of the equipment. Replacement batteries are not covered.

Bras designed to hold external breast **prostheses** after a mastectomy are considered **durable medical equipment**. Coverage will be limited to the standard models as determined by **us**. Coverage is provided for 2 prosthetic bras at the time a **prosthesis** is acquired. **Covered services** include the replacement of prosthetic bras due to wear and tear, but only after the **covered person** has had the prosthetic bra for at least one year, and only on an annual replacement basis thereafter during the time an external **prosthesis** is used. There is no coverage for bras if **reconstructive surgery** is done.

10. ELECTIVE STERILIZATIONS

Vasectomies and tubal ligations, for **covered employees** and dependent **spouses** only.

11. **EMERGENCY CARE** SERVICES

Coverage is provided for **emergency care**. **Emergency care** obtained through a **non-network provider** (other than ambulance services) is covered as if received through a **network provider** if the event requiring **emergency care** meets the definition of an **emergency condition**. In order to continue to receive **benefits** at the **network provider** level shown in the **schedule**, continuing or follow-up treatment must be provided by a **network provider**.

In case of an **emergency condition**, the **covered person** should obtain **emergency care** from the nearest emergency facility.

12. **HOME HEALTH CARE** SERVICES

(Pre-Certification Required)

Services provided in the **covered person's** place of residence for part-time or intermittent **home health care** if the **covered person** is homebound. A **covered person** will be considered to be homebound if he has a condition due to **illness or injury** which restricts his ability to leave his place of residence and/or leaving the home is medically inappropriate. **We** have the right to determine whether the **covered person** is homebound.

Home health care services must be provided by or through a **home health care agency**. A maximum of 100 **home health care** visits are payable in any **calendar year**. Each visit by an authorized agent of a **home health care agency** is considered one visit. In order for **covered services** to be payable, the **covered person's physician** must certify that:

a. confinement in a **hospital** or **nursing facility** would be required in lieu of **home health care**; and

b. the **home health care** services will be provided or coordinated by a **home health care agency**, which is qualified under **Medicare**.

A service shall not be considered a **skilled nursing service** merely because it is performed by, or under the **direct supervision** of, a nurse. Where a service or like services can be safely and effectively performed by a non-medical person without the **direct supervision** of a nurse, the service shall not be regarded as a **skilled nursing service**, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a nurse provides it. Only the skilled nursing component of so-called ″blended″ services (i.e., services which include skilled and non-skilled components) are covered.

The maximum weekly benefit for this coverage will not be more than the **benefits** payable for the total weekly charges for **skilled nursing care** available in a **nursing facility**, as determined by **us**.

13. HOSPICE CARE SERVICES

(Pre-Certification Required)

Hospice care ordered by a **physician** and provided by a **hospice agency**. In order to qualify for coverage, a **covered person** must be diagnosed with a covered **illness or injury** and be terminally ill with a life expectancy of six (6) months or less. **Covered services** may be provided either in the home or at **inpatient** facilities and may be provided on an intermittent, **scheduled** or round-the-clock basis. For **covered services** to be payable, **we** must receive a written statement from the attending **physician** that the **covered person** is terminally ill and only receiving palliative and supportive care.

When hospice care is in lieu of an admission to a **hospital** or **nursing facility**, coverage is provided for the following hospice services:

a. room and board and other services and supplies;

b. part-time nursing care by or supervised by a registered nurse (RN);

c. counseling services by a licensed clinical social worker or pastoral counselor for the **covered person** and immediate family;

d. medical social services provided to the **covered person** and his immediate family under the direction of a **physician**. Services include:

   i. assessment of social, emotional and medical needs, and the home and family situation; and

   ii. identification of the community resources available and assisting in obtaining those resources;

e. dietary counseling;

f. consultation and case management services by a **physician**;

g. **physical therapy** or **occupational therapy**;

h. part-time home health aide service; and

i. medical supplies, drugs and medicines ordered by a **physician**.

14. **HOSPITAL**, AMBULATORY SURGERY AND SURGERY CENTER SERVICES

(Pre-Certification Required)

a. **Inpatient** Services (Pre-Certification Required): Medical or surgical services for the treatment of **illness or injury**, which requires the level of care only provided in a **hospital**. These services must be ordered by a **physician**.

We cover charges for room and board for occupancy of semiprivate or lesser accommodations. Nursing services (private duty and **incremental nursing**) are included in the charges for room and board and are not **covered services**. If a **covered person** is in a private room, **we** will pay **benefits** at the hospital's most common semiprivate daily rate or if there is no semiprivate room rate, 95% of the private room rate. If a **covered person** is in an **intensive care unit**, **we** will pay the **intensive care unit** room rate.

When multiple **surgical** procedures are done in the same operative session, **covered expenses** include the **reasonable and customary charge** for a single operating room charge or a single **facility fee**. There is no coverage for additional operating room charges or **facility fees** during the same operative session.

Charges for personal convenience services and items are not covered.

b. **Outpatient,** Ambulatory or Surgical Services (Pre-Certification Required; see **schedule** for procedures requiring pre-certification): Medical and surgical services for diagnosis or treatment of **illness or injury** on an **outpatient** basis. These services must be ordered by a **physician**.

When multiple **surgical** procedures are done in the same operative session **covered expenses** include the **reasonable and customary charge** for a single operating room charge or a single **facility fee**. There is no coverage for additional operating room charges or **facility fees** during the same operative session.

15. MANIPULATIVE THERAPY

Services by a **physician** or someone under his **direct supervision** for **manipulative therapy** and related services. A maximum of 26 visits for **manipulative therapy** and related services are payable in any **calendar year**. Each calendar day a **covered person** receives **manipulative therapy** is considered one visit.

16. MASTECTOMY

(Pre-Certification Required)

Services in connection with a mastectomy for which **benefits** are payable under the **policy** including:

a. reconstruction of the breast on which the mastectomy has been performed;

b. **surgery** and reconstruction of the other breast to produce a symmetrical appearance;

c. **prostheses** to replace the breast on which the mastectomy has been performed (refer to Section VI - **Covered Services**, 28. **Prosthetic Devices** regarding repairs or replacement); and

d. physical complications resulting from all stages of the mastectomy, including lymphedema.

These services are provided in a manner determined in consultation between the **covered person** and his **physician**.

17. MATERNITY SERVICES

(Pre-Certification Required for **inpatient** stays over the minimum duration below)

Maternity services include:

a. Prenatal and postnatal care, complications, and delivery.

b. A minimum of 48 hours of **inpatient** care following a vaginal delivery in addition to the day of delivery.

c. A minimum of 96 hours of **inpatient** care following a cesarean section in addition to the day of delivery.

d. Maternity management and support provided through **our** review organization.

Coverage is also provided for **covered services** rendered by a **nurse midwife** or at a **birthing center**.

Treatment, services or supplies received by the newborn child are covered under the coverage for the child, not the mother. These treatments, services and supplies, including nursery charges, are subject to the child's **deductible**, **coinsurance** or **copayments**.

18. **MEDICAL SUPPLIES**, OXYGEN & OTHER GASES

    a. Coverage is provided for **outpatient** and **inpatient** use of **medical supplies** prescribed by a **physician** for treatment of an **illness or injury**; and

    b. Coverage is provided for **outpatient** and **inpatient** use of oxygen and other gases for treatment of an **illness or injury**.

19. **MENTAL ILLNESS** SERVICES

    (Pre-Certification Required for **inpatient** or transitional treatment)

    See **schedule** for **calendar year** and **lifetime maximum** limits.

    a. **Outpatient** Services: **We** cover **outpatient** mental health services for evaluation, crisis intervention, and treatment of **mental illness** provided by a **physician** or a licensed professional under his **direct supervision**. A comprehensive diagnostic assessment must be the basis for a determination by a **physician** concerning the appropriate treatment and the extent of services required. The services must be furnished under a written plan established by a **physician** and regularly reviewed by the **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

    b. **Inpatient** Services: **We** cover **inpatient** services in a **hospital** located in the **covered person's** state of residence, and **physician** services for treatment of **mental illness**. Care received in an **inpatient hospital** eating disorder unit for an eating disorder is covered. This does not include medical stabilization.

    c. Transitional Treatment Arrangements: Services are covered for a transitional treatment arrangement. "Transitional treatment arrangement" means services for the treatment of **mental illness** that are provided to a **covered person** in a less restrictive manner than **inpatient** services but in a more intensive manner than **outpatient** services.

       Transitional treatment includes:

       i. Mental health services for **covered persons** in a certified or licensed **day treatment** program offered by a **provider** located in the **covered person's** state of residence.

       ii. Services for **covered persons** with chronic **mental illness** provided through a certified or licensed community support program located in the **covered person's** state of residence.

       Transitional treatment does not include halfway houses or programs.

20. MUSCULOSKELETAL DISORDERS

    (Pre-Certification Required for surgery)

    Expenses to treat musculoskeletal disorders of any bone or joint of the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Any **surgical** procedure must be pre-certified.

21. **NURSING FACILITY** SERVICES

    (Pre-Certification Required)

    Room, board, and general nursing services for a semi-private room in a **nursing facility**. Coverage is limited to the facility's semi-private room rate or 50% of the semi-private rate at the **hospital** the **covered person** was in prior to this confinement, whichever is less. Other services provided at the **nursing facility** will only be covered if they are **covered services** under the **policy**.

    In order for such charges to qualify as **covered services**:

    a. the confinement must begin within 24 hours after an **inpatient hospital** confinement which is covered under the **policy**; and

    b. the confinement must be due to the same condition for which care was received in the **hospital**.

    Coverage is limited to a maximum of 60 days per confinement not to exceed 60 days for any one **illness or injury**.

22. NUTRITION COUNSELING AND MEDICAL FOODS

Coverage is provided for:

a. nutrition counseling ordered by a **physician** and provided by a registered dietitian for treatment of an **illness or injury**; or

b. medical foods for treatment of PKU (phenylketonuria) for covered persons under age 19.

23. **ORTHOTIC DEVICES**

Pre-Certification Required)

The purchase, fitting, necessary adjustments, repairs, and replacements due to normal wear and tear of **orthotic devices**.

Coverage for **orthotic devices** will be limited to the standard models as determined by **us**. The **covered person** is responsible for paying any amount in excess of the charge for the standard model. **Covered services** include subsequent repairs necessary to restore the most recently purchased **orthotic device** to a serviceable condition. Repairs due to abuse or misuse, as determined by **us**, of the **orthotic device** are not covered.

Covered services include the replacement of **orthotic devices** that have been outgrown due to normal skeletal growth. **Covered services** include the replacement of **orthotic devices** due to wear and tear, but only after the **covered person** has had the **orthotic device** for at least five years, and only on a five-year replacement basis thereafter.

24. **PRESCRIPTION DRUGS**

If a **covered person** incurs expenses for **prescription drugs**, **we** will pay **benefits** as provided in the **schedule**. Payment of any **benefits** will be subject applicable limits set forth in the **schedule**.

Covered expense for **prescription drugs** is limited to the **network** cost of the drug. This applies to drugs purchased from a **network** or **non-network provider**.

25. PREVENTIVE CARE SERVICES

An **illness or injury** is not required for coverage under this section. The following services are preventive care services:

a. evidence-based items or services that have in effect a rating of ″A″ or ″B″ in the current recommendations of the United States Preventive Services Task Force;

b. immunizations for routine use 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 **covered person** involved;

c. for **covered 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;

d. for **covered persons** who are women, such additional preventive care and screenings not described above as provided or in comprehensive guidelines supported by the Health Resources and Services Administration; or

e. P**hysician** delivered **outpatient** physical examination of the **covered person's** general health (annual physical). This coverage is limited to one physical examination per **calendar year** and is subject to the limit in the **schedule**.

Coverage for preventive **benefits** does not require payment of any **deductible**, **copayment**, or **coinsurance** if preventive care services are obtained from a **network provider** as part of an **office visit**. Preventive care services do not include testing done by mobile diagnostic units or wellness exams or wellness evaluations that are not obtained from a **network provider** as part of an **office visit**.

Preventive care services received from a **non-network provider** are subject to **non-network deductible** and **coinsurance**.

Preventive care services do not include any tests or immunizations necessary for the diagnosis or direct care and treatment of an **illness or injury**. Preventive care services do not include "surveillance testing". "Surveillance testing" are tests or screenings done when a **physician** is monitoring a known condition; or when a known risk factor exists; or tests or screenings done outside the guidelines listed above. "Surveillance testing" is treatment of an **illness or injury** not preventive care services. **Medically necessary** "surveillance testing" will be subject to **deductible**, **copayment**, and **coinsurance**.

26. PROFESSIONAL SERVICES - **PHYSICIAN** SERVICES

    a. **Office Visit** or **urgent care visit** - **Physician** services for treatment of an **illness or injury** billed as an **office visit**.

    b. Other Charges - **Physician** services for treatment of an **illness or injury** billed as other than an **office visit**. This includes electronic consultations.

    Physician services that are specifically listed in any other subsection are not **covered services** under this subsection. **Facility fees** are not covered as part of an **office visit** or **urgent care visit**.

27. PROFESSIONAL SERVICES - **SURGERY**

    (Pre-Certification Required; see **schedule** for procedures requiring pre-certification)

    Physician surgery charges for treatment of **illness or injury**. **Physician** charges for post-operative care are included with the amount payable for the **surgery**. **Covered services** include services rendered by an assistant at surgery when **medically necessary**. Coverage for an assistant at surgery who is a licensed medical doctor is limited to 20% of the **covered expense** for the **surgical** procedure. Coverage for an assistant at surgery who is not a licensed medical doctor is limited to 10% of the **covered expense** for the **surgical** procedure.

    When multiple **surgical** procedures are done at the same time, **covered expenses** include the **reasonable and customary charge** for the first or major procedure. **Covered expenses** for the 2nd and 3rd additional procedures are limited to a maximum of 50% of the **reasonable and customary charge**. **Covered expenses** for the 4th and subsequent additional procedures are limited to a maximum of 25% of the **reasonable and customary charge**. There is no coverage for incidental **surgical** procedures.

28. **PROSTHETIC DEVICES**

    (Pre-Certification Required)

    The purchase, fitting, necessary adjustments, repairs, and replacements due to normal wear and tear of **prosthetic devices**.

    Coverage for **prosthetic devices** will be limited to the standard models as determined by **us**. The **covered person** is responsible for paying any amount in excess of the charge for the standard model. **Covered services** include subsequent repairs necessary to restore the most recently purchased **prosthetic device** to a serviceable condition. Repairs due to abuse or misuse, as determined by **us**, of the **prosthetic device** are not covered.

    Covered services include the replacement of **prosthetic devices** that have been outgrown due to normal skeletal growth. **Covered services** include the replacement of **prosthetic devices** due to wear and tear, but only after the **covered person** has had the **prosthetic device** for at least five years and only on a five-year replacement basis thereafter.

    Benefits are provided for a penile **prosthetic device** required for physiological (not psychological) impotence.

29. **RECONSTRUCTIVE SURGERY**

    (Pre-Certification Required)

    Reconstructive surgery is limited to **surgery** that has the primary purpose of restoring function after an **illness or injury**, or is the result of a **congenital defect**. If the reason for **surgery** meets the criteria of restoring function, then coverage is available even if there is an incidental improvement in physical appearance.

30. REHABILITATIVE SERVICES

    (Pre-Certification Required)

    a. Treatment as an **inpatient** in a rehabilitative unit of a **hospital** or a rehabilitative facility for acute conditions or injuries.

b. **Outpatient** cardiac rehabilitation. Coverage is provided only if an **outpatient** exercise program is begun within 30 days following discharge from an **inpatient hospital** admission for a cardiac related condition. A maximum of 36 supervised and monitored exercise sessions are covered in a 12 consecutive week period, starting with the first session in the **outpatient** exercise program.

31. THERAPIES

(Pre-Certification Required)

a. **Physical Therapy** - Coverage is provided for **physical therapy** when rendered by a licensed physical therapist under the supervision of a **physician**. The therapy must be furnished under a written plan established by a **physician** and regularly reviewed by the therapist and the **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

b. **Occupational Therapy** - Coverage is provided for **occupational therapy** when these services are rendered by a licensed occupational therapist under the supervision of a **physician**. This therapy must be furnished under a written plan established by a **physician** and regularly reviewed by the therapist and **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

c. **Speech Therapy** - Coverage is provided for **speech therapy** when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association under the supervision of a **physician**. This therapy must be furnished under a written plan established by a **physician** and regularly reviewed by the therapist and **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

d. Intravenous Therapy - coverage is provided for intravenous therapy including chemotherapy if ordered by a **physician**. This therapy must be furnished under a written plan established by a **physician** and regularly reviewed by the therapist and **physician**. The plan must be established before treatment begins and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

32. TRANSPLANT SERVICES - HUMAN ORGAN AND BONE MARROW

(Pre-Certification Required)

a. If the transplant recipient is a **covered person,** coverage is provided for transplant related services and supplies that are **medically necessary** for the recipient and are not **experimental or investigational** and/or for research.

b. If the donor and recipient are **covered persons**, coverage is provided for transplant related services and supplies that are **medically necessary** for the donor and are not **experimental or investigational** and/or for research. Coverage for the donor's expenses will be provided subject to the donor's **schedule** of benefits including applicable **deductible**, **copayments** and **coinsurance**.

c. If the donor is not a **covered person,** coverage will be provided for transplant related services and supplies that are **medically necessary** for the donor and are not **experimental or investigational** and/or for research only if the donor does not have any form of health insurance coverage that provides coverage for the services. The **benefits** paid for the donor's **covered expenses** will be subject to a separate **deductible** and **coinsurance** equal to the **deductible** and **coinsurance** shown in the **schedule** for the **covered person** who is the recipient. This coverage only applies for transplants covered under the **policy**.

d. If the recipient is a **covered person** expenses related to donor matching are **covered services** only if the potential donor does not have any form of health insurance coverage that provides coverage for the services. The **benefits** paid for donor matching will be subject to a separate **deductible** and **coinsurance** equal to the **deductible** and **coinsurance** shown in the **schedule** for the **covered person** who is the recipient. This coverage only applies for transplants covered under the **policy**.

e. Coverage is not provided for transplant related services and supplies provided to donors or recipients if the transplant recipient is not a **covered person**. This includes transplants where the donor or potential donor is a **covered person**.

SECTION VII - EXCLUSIONS

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

The following exclusions apply to all coverages described in the **policy**. Coverage is not provided for and no **benefits** will be paid for:

1. Charges for treatment, services or supplies that are not listed as **covered services** in Section VI - **Covered Services**.
2. Treatment, services or supplies that are not **medically necessary**. **We** have the right to determine when treatment, services or supplies are not **medically necessary**. The exclusion of a treatment, service or supply as not **medically necessary** is a determination about **benefits** and is not a medical treatment decision or recommendation. The **covered person** may choose to obtain the treatment, service or supply at their own expense.
3. Treatment, services or supplies that are not approved under Section I - General Provisions, 16. Pre-Certification Requirements when required by the **policy**.
4. Treatment, services or supplies:
   a. not ordered by a **physician**;
   b. continued after a **physician** has advised that further care is not necessary; or
   c. ordered by a **physician** at the request of the **covered person**.
5. Charges for **covered services** that exceed the **reasonable and customary** amount.
6. Any drug, device or medical treatment or procedure and related treatment, service or supply that is **experimental or investigational**.
7. Treatment, services or supplies required in connection with, in follow-up to, or as a result of a treatment, service or supply not covered under the **policy**. This includes treatment, services and supplies required as a result of complications of a medical procedure not covered under the **policy**.
8. Treatment, services or supplies:
   a. for which a charge would not have been made in the absence of insurance or health plan coverage;
   b. for which it has been determined the **covered person** is not legally obligated to pay;
   c. from **providers** who waive **copayment**, **deductible** or **coinsurance** payments by the **covered person**;
   d. where the **provider** would normally make no charge;
   e. that the **provider** advertises as free;
   f. for emergency response or rescue services that do not involve emergency transportation of the **covered person**; or
   g. to the extent that payment is unlawful where the **covered person** resides.
9. Treatment, services or supplies provided when a **covered person's** coverage was not in effect under the **policy**. This includes care provided either prior to the effective date of coverage or after such coverage ends.
10. Treatment, services or supplies for **pre-existing conditions** when the **pre-existing condition** provision applies (see Section II - Enrollment & Effective Date for application of the provision).
11. **Medical supplies** not ordered by a **physician** or first aid supplies. This includes but is not limited to gloves, diapers, gauze, bandages, tape and dressings.
12. Treatment, services or supplies including **prescription drugs** for **illness** or **injuries** related to the **covered person's** job. This exclusion applies to any **illness** or **injury** that is covered or is required by law or regulation to be covered by **Workers' Compensation**. This exclusion applies if coverage under **Workers' Compensation** is required by law or regulation and was not purchased by the **covered person's** employer. This exclusion applies even if the **covered person** does not submit a claim to the **Workers' Compensation** insurer for an **illness or injury** related to their job.

If the **covered person** enters into a settlement giving up his right to recover past or future medical benefits under **Workers' Compensation**, **we** will not pay past or future medical expenses that are the subject of or related to that settlement. In addition, if a **Workers' Compensation** program limits benefits if other than specified **providers** are used, and treatment, services or supplies are received from a **provider** not specified by the program, **we** will not pay charges from such non-specified **providers**.

13. Coverage under the **policy** will not duplicate coverage provided or required to be purchased or provided under Federal, State, or local laws, regulations or programs. This exclusion applies whether or not the **covered person** chooses to waive his rights to these programs or coverages. This exclusion applies if the **covered person** does not purchase coverage required by law or regulation.

    This exclusion does not apply to **Medicaid**. **We** will provide coverage on a primary or secondary basis as required by state or federal law.

    This exclusion includes treatment, services and supplies for which payment was made or would have been made under **Medicare** Parts A or B if the **covered person** had enrolled. This applies if the **covered person** is eligible for **Medicare** even if they did not enroll for coverage or claim benefits.

14. Charges for treatment, services and supplies that do not follow the American Medical Association (AMA) billing guidelines, uniform billing (UB) guidelines and/or applicable state or federal laws and regulations. This includes, but is not limited to:

    a. the unbundling of service codes that can be billed as a single code;

    b. billing incorrectly or separately for services that are an integral part of another service;

    c. the upcoding of service codes; and

    d. billing nursing services separate from room and board charges for **inpatient** confinements.

15. Bills (including additions to prior bills) that are submitted more than two years after a treatment, service or supply was received.

16. Treatment, services or supplies not related to an **illness or injury** except as provided in Section VI - Covered Services, 25. Preventive Care Services. This includes but is not limited to:

    a. physical examinations or services required by an insurance company to obtain insurance;

    b. physical examinations or services required by a government agency such as the FAA or DOT;

    c. physical examinations or services required by an employer in order to begin or to continue working or obtain a license of any kind;

    d. physical examinations or services required for marriage or adoption;

    e. screening examinations outside the medical guidelines for recommended ages or frequency;

    f. physical examinations or services required for school or sports or camp;

    g. physical examinations or services required for travel;

    h. drug screening or testing;

    i. functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits; or

    j. work-hardening programs or vocational rehabilitation services.

17. **Hospital**, facility, or other treatment, services or supplies when the **covered person** is unnecessarily admitted to and/or retained in the **hospital** or facility for treatment and evaluations that could satisfactorily be made on an **outpatient** basis. The treatment, services or supplies that would be covered as an **outpatient** will be covered.

18. Treatment, services or supplies for **illness** or **injuries** caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.

19. Payment to donors of blood and charges for blood and blood plasma that has been replaced.

20. **Cosmetic surgery**. Complications of **cosmetic surgery** are also not covered. This includes surgery to correct a **congenital defect** for psychological reasons where there is no functional impairment. This exclusion also includes removal of excess skin after weight loss regardless of how the weight was lost.

21. **Maintenance care** or **custodial care**.

22. Treatment, services or supplies related to any mass screening type of physical or health examination. This includes, but is not limited to:

    a. mobile diagnostic units;

    b. employer sponsored physicals or screenings; and

    c. wellness exams not performed in a **physician's** office.

23. Physical, psychiatric, or psychological examinations, testing, vaccinations, immunizations, prescription drugs or treatments, if they are conducted for purposes of medical research.

24. Alternative and/or complementary therapies, treatment, services or supplies including, but not limited to:

    a. Energy therapies such as:

        i. acupuncture, electro-acupuncture or acupressure;

        ii. cupping or fire cupping;

        iii. healing touch;

        iv. magnetic therapy;

        v. reiki;

        vi. shock wave therapy; or

        vii. zone therapy.

    b. Mind-body medicine such as:

        i. biofeedback or relaxation therapy;

        ii. guided imagery;

        iii. hanna somatics;

        iv. herbal or aroma therapy;

        v. hypnosis;

        vi. meditation;

        vii. past life therapy;

        viii. recreational therapy;

        ix. somatic education;

        x. spiritual healing;

        xi. therapies using art, dance, humor or sound; or

        xii. visualization therapy.

    c. Hands on therapy such as:

        i. alexander technique;

        ii. craniosacral therapy;

        iii. feldenkrais method;

        iv. manual lymph drainage;

        v. massage or massotherapy;

        vi. moxibustion;

        vii. myofascial release;

        viii. polarity therapy;

        ix. reflexology;

x. rolfing;

xi. rosen method;

xii. shiatsu;

xiii. therapeutic touch;

xiv. trager psychophysical integration; or

xv. trigger point or myotherapy.

d. Movement therapies such as:

i. pilates;

ii. qi gong;

iii. tai chi; or

iv. yoga.

e. Animal therapies including but not limited to dolphin or hippotherapy.

f. Ayurveda.

g. Chinese medicine.

h. Colon therapy.

i. Herbal medicine.

j. Holistic medicine.

k. Homeopathy.

l. Lovaas therapy or applied behavioral analysis.

m. Naturopathy.

n. Prolotherapy.

o. Rest cures.

p. Systemic candidiasis or immunoaugmentive therapy.

q. VNS therapy.

25. Treatment, services or supplies including prescription drugs related to gender or sexual reassignment. This includes sexual transformation or intersex surgery. All related complications are also excluded.

26. Laboratory charges for professional services on tests that do not involve direct intervention by a pathologist or other **provider**. Direct intervention means interpretation of the laboratory tests including a written report and/or consultation with the treating **physician** regarding results of the laboratory test.

27. Treatment, services or supplies required in connection with, in follow-up to, or as a result of a **never event**.

28. Educational training or other services designed or adapted to develop a physical function and testing or training related to learning disabilities or developmental delays.

29. Treatment, services or supplies for diagnosis or treatment of fertility or infertility including related **hospital** or **physician** services and medications. This includes, but is not limited to:

a. artificial insemination or fertilization;

b. donor sperm;

c. the processing and storage of semen, eggs or embryos;

d. in vivo or in vitro fertilization;

e. embryo transfer;

f. gamete intrafallopian transfer (GIFT) and similar procedures;

g. amniocentesis or chorionic villi sampling (CVS) solely for sex determination;

h. surrogate pregnancy treatment, services or supplies when the surrogate is not a **covered person**;

i. cloning methods;

j. laboratory tests;

k. **prescription drugs**;

l. assisted reproductive technology;

m. genetic counseling;

n. the reversal of sterilization procedures; and

o. **surgical** procedures.

30. Treatment, services or supplies to treat hair loss or unwanted hair growth or to promote hair growth. This includes, but is not limited to, prescription or non-prescription drugs, laser treatments, hair transplants, wigs and cranial **prosthetics**.

31. Charges for personal items, provided on an optional basis including, but not limited to, television, radio, telephone or comfort kits.

32. Time spent traveling or services for or related to, transportation:

    a. not necessary for basic or advanced life support;

    b. to or from **physician** visits;

    c. to or from therapy; or

    d. home from the **hospital**.

33. Treatment, services or supplies provided by the **covered person** or a **close relative** or member of the **covered person's** household or legal guardian of the person who received the service. "Member of the **covered person's** household" means anyone who lives in the same household or who was claimed as a tax deduction for the year during which the service was provided.

34. All dental care not specifically covered in Section VI - Covered Services, 7. Dental Services. This exclusion applies regardless of the **medical necessity** of or the underlying cause for the need for the dental care. Exclusion from coverage is based on the type of service provided and the anatomical structure on which the procedure is performed.

35. Irreversible treatment that permanently alters the teeth or bite, including but not limited to removal of teeth, crowns, bridgework, dentures, implants and orthodontic appliances (braces). This exclusion applies regardless of the **medical necessity** of or the underlying cause for the need for the treatment. Exclusion from coverage is based on the type of service provided and the anatomical structure on which the procedure is performed.

36. Treatment, services or supplies for, or related to

    a. disorders of refraction or accommodation that are correctable by eyeglasses or contact lenses;

    b. determining the need for or the proper adjustment of glasses or contact lenses including but not limited to: lenses, frames, contact lenses, and other fabricated optical devices; eye examination or refractions; and professional treatment services or supplies for the fitting and/or supply of eyeglasses, contact lenses or other optical devices;

    c. surgical treatment of refractive errors including but not limited to laser vision corrections, radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature; and

    d. orthoptic and visual training or therapy.

37. Educational services not specifically covered in Section VI - Covered Services.

38. Nursing services. This includes:

    a. private duty nursing (both **inpatient** and **outpatient**); and

    b. **incremental nursing** charges in connection with **inpatient hospital** services.

39. All food, formula and nutritional supplements. This includes, but is not limited to, breast milk, infant formulas, enteral feeding and support, dietary formulas, protein or caloric boosting supplements, herbal preparations or supplements, liquid diets and vitamins. This exclusion applies even if such items are approved by the Food and Drug Association (FDA). This exclusion does not apply to medical foods for treatment of PKU (phenylketonuria) for **covered persons** under the age of 19.

40. For medications or drugs:

    a. that are available in the equivalent doses over-the-counter;

    b. that do not require a prescription by Federal or State law;

    c. refilled in excess of the number specified by the **physician** or any refill after one year from the **physician's** original order;

    d. labeled "Caution - Limited by Federal Law to Investigational Use", or **experimental or investigational** drugs;

    e. that are or may be properly received without charge under state, local or federal programs;

    f. in amounts or quantities in excess of Federal Drug Administration limits and/or indications;

    g. used to enhance the appearance or lifestyle of the **covered person**;

    h. that are anabolic steroids;

    i. for or leading to or after gender reassignment including but not limited to hormones;

    j. for treatment of fertility, infertility artificial insemination, or fertilization methods;

    k. used or prescribed off label unless required by state law;

    l. that are a replacement or reimbursement for lost, stolen, forgotten or damaged medications;

    m. that are smoking cessation drugs in excess of a 90 day supply each **calendar year** for a maximum of 3 **calendar years**;

    n. that are medical marijuana;

    o. prescribed to treat any **illness or injury** not covered by the **policy**;

    p. that are cosmetic drugs and medicines or health and beauty aids;

    q. that are vitamins or herbal supplements; or

    r. that are obtained from outside the United States or through an internet pharmacy or supplier.

    This exclusion applies even if these items are provided or prescribed by a **physician**.

41. Transplant treatment, services or supplies related to:

    a. purchase of human organs for transplant; and

    b. mechanical or animal organs.

42. Termination of pregnancy using abortion or other procedures; over the counter or prescription **drugs**; or other devices. This includes any treatment, services or supplies related to (either before or after) the abortion. This exclusion applies regardless of the **medical necessity** of or the underlying cause for the need to terminate the pregnancy.

43. Treatment, services or supplies that do not meet generally accepted standards of practice in the United States medical community. Treatment, services or supplies that are not provided in accordance with generally accepted medical practice and management currently used in the United States. Treatment services or supplies that are not provided at the most appropriate level of medical care that is needed to provide safe, adequate and appropriate diagnosis or medical treatment.

44. Treatment, services or supplies related to alternative allergy diagnosis or treatments. This includes, but is not limited to, sublingual drops, systemic candidiasis or immunoaugmentive therapy.

45. Treatment, services or supplies related to alcohol abuse or drug abuse as described in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition - revised (DSM-IV-R) or subsequent revision to DSM-IV-R.

46. Detoxification due to use of alcohol or drugs that is not treatment of **chemical dependency**.

47. Treatment, services or supplies provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials or as part of a judicial process. This includes, but is not limited to, treatment, services, supplies, evaluations, testing or confinements:

    a. ordered by a court or law enforcement officers;

    b. required to file or respond to an action with a court; or

    c. required for or related to parole or probation.

48. Treatment, services or supplies related to lifestyle issues that are not the result of an **illness** or **injury**. This includes, but is not limited to, treatment of compulsive gambling, marital counseling, goal oriented behavioral modification therapy, nicotine addiction and smoking cessation programs.

49. Treatment, services or supplies for, or related to, charges for:

    a. failure to keep a scheduled visit;

    b. completion of any form;

    c. providing medical information or records;

    d. completing pre-certification or referral procedures;

    e. patient advocacy; or

    f. service fees, concierge fees, access charges or any other charge related to maintaining a doctor/patient relationship.

50. Any treatment, services or supplies for, or related to, fetal tissue transplantation.

51. Treatment, services or supplies for, or related to, gene therapy as a treatment for inherited or acquired disorders.

52. Treatment, services or supplies for, or related to, growth hormone replacement therapy except for conditions that meet **medical necessity** criteria.

53. Treatment, services or supplies for, or related to, internal, external, or implantable hearing aids or devices, and related fitting or adjustment. **We** do cover **medically necessary** cochlear implants and related fitting or adjustments.

54. Treatment, services or supplies that were not received from a covered **provider**.

55. Treatment, services or supplies to remove or repair or modify:

    a. a birthmark;

    b. tattoo;

    c. body modification; or

    d. piercing.

    This exclusion does not apply to treatment by a **physician** for the **medically necessary** removal of a birthmark including "port-wine stains."

56. The following charges in conjunction with an **office visit** or **urgent care visit** or **emergency care visit**:

    a. after hours charges or fees;

    b. overhead for facilities or equipment;

    c. holiday charges or fees; or

    d. house call charges or fees.

57. For **durable medical equipment** or **prosthetic devices** or **orthotic devices**:

    a. replacement or repair if the currently used item is damaged or destroyed by misuse, abuse or carelessness; lost; or stolen;

    b. duplicate or similar items to equipment or devices the **covered person** has;

c. that have special features which are not **medically necessary** for the **covered person's** medical condition;

d. rental charges that exceed the **reasonable and customary** charges for the purchase of the equipment or device;

e. that are communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids, fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication;

f. that are household furnishings or fixtures including, but not limited to, escalators or elevators, ramps, grab bars, railings, standing frames, wheelchair lifts, stair lifts, whirlpools, whirlpool tubs or equipment, swimming pools and saunas, air conditioners, air purifiers, humidifiers, dehumidifiers, stair glides, Emergency Alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, exercise and massage equipment;

g. modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment;

h. vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier;

i. rental equipment while the **covered person's** own equipment is being repaired. However, **we** will provide coverage for one-month rental of **medically necessary** equipment or devices;

j. replacement batteries. Original batteries will be included for covered **durable medical equipment** or **prosthetic devices**;

k. equipment or devices that are primarily and customarily used for nonmedical purpose or used for environmental control or enhancement (whether or not ordered by a **physician**). This includes, but is not limited to, exercise bikes, air purifiers, air conditioners, humidifiers, dehumidifiers, water purifiers, hypoallergenic mattresses, underpads, bed tables, tub bench, bedpans, personal computers and related equipment, breast pumps, bed wetting alarms, and home blood pressure kits;

l. that are appliances for snoring;

m. that are uterine monitors during pregnancy prescribed for home use;

n. that are designed to affect performance in sports related activities;

o. that are oral or dental appliances;

p. **orthotic devices** that are not custom fitted to the **covered person**;

q. that are penile **prosthesis** required for psychological impotence; or

r. other equipment or devices that **we** determine are not eligible for coverage.

58. Treatment, service or supplies for weight control or reduction. This includes, but is not limited to:

a. nutritional supplements;

b. **prescription drugs** or over the counter drugs or diet aids;

c. dietary or nutritional counseling;

d. individual or behavior modification therapy;

e. body composition or underwater weighing procedures;

f. exercise therapy;

g. weight control or reduction programs; or

h. any obesity surgery including but not limited to lap band, stomach stapling, gastric bubble, intestinal or stomach bypass, liposuction or suction lipectomy.

Additionally there is no coverage for removal of excess skin after weight loss regardless of how the weight was lost. This exclusion applies even if the **covered person** has other health conditions that might be treated or relieved or cured by weight control or reduction.

59. Chelation (metallic ion therapy), except in the treatment of heavy metal poisoning.

60. Charges incurred outside the United States if:
    a. the **covered person** traveled to such location for the purpose of obtaining medical treatment, services, supplies, or **prescription drugs**; or
    b. the **covered person** obtained the medical treatment, services, or **prescription drugs** from outside the United States or through an internet pharmacy or supplier.
61. Cryopreservation or cryostorage.
62. Health club memberships.
63. **Home health care** expenses are not payable for the following services or supplies:
    a. services or supplies that exceed the prescribed treatment plan;
    b. food, housing, and home delivered meals;
    c. homemaker services or supplies, such as light housekeeping, laundry, shopping, and simple errands;
    d. teaching household routines to well members of the family, supervision of children, and other similar functions;
    e. services or supplies provided by a **close relative** or someone who lives in the home;
    f. services or supplies provided by volunteer associations for which the **covered person** does not have to pay;
    g. services or supplies of visiting teachers, visitors, vocational guidance, and other counselors;
    h. services or supplies related to diversional, occupational, and social activities; or
    i. services or supplies provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home.
64. Hospice care services do not include:
    a. private or special nursing services;
    b. an **inpatient** admission not required for pain control or other acute chronic symptom management;
    c. funeral arrangements;
    d. financial or legal counseling including estate planning or drafting of a will;
    e. homemaker or caretaker services including a sitter or companion services;
    f. house cleaning or household maintenance;
    g. services of a social worker, other than a licensed clinical social worker;
    h. services by volunteers or persons who do not regularly charge for his services; or
    i. services by a pastoral counselor not on staff at the **hospice agency**.
65. Treatment, services or supplies related to any genetic testing or genetic screening or genetic counseling.
66. Treatment, services or supplies for, or related to mammoplasty, gynecomastia, mastopexy, breast reduction, breast augmentation, breast reshaping, breast lift, breast enlargement or breast reconstruction. This includes insertion, removal, replacement or revision of breast implants and revision of breast reconstruction. This exclusion does not apply to breast reconstruction done as part of treatment related to mastectomy required to be covered by the Women's Health and Cancer Rights Act. This exclusion applies regardless of the **medical necessity** of the underlying cause of surgery or other medical procedure.
67. Treatment, services or supplies for or related to spinal unloading or non-surgical spinal decompression, including, but not limited to Vax D, disc decompression, vertebral axial decompression or intervertebral traction.
68. Treatment, services or supplies for or related to water circulating cold pads or compression systems; heating or cooling units; ice bags; heating pads; or cold therapy units.
69. **Manipulative therapy** of the cervical spine.

70. Treatment, services or supplies related to an **illness or injury** caused by the **covered person's**:
    a. commission of or attempt to commit a felony; or
    b. engagement in an illegal occupation.
71. Foot care except when needed for illness or injury. This includes but is not limited to:
    a. hygienic or preventive maintenance foot care;
    b. treatment of flat feet;
    c. shock wave therapy to the feet;
    d. laser treatment of mycotic nails (nail fungus); and
    e. treatment of subluxation of the foot.
72. Treatment, services or supplies for snoring except when provided for documented obstructive sleep apnea.
73. The cost of **prescription drugs** in excess of the **network** cost of the drugs.

SECTION VIII - DEFINITIONS

Words and phrases appearing in **bold type** in the **policy** have special meaning as set forth below.

1. **Active Work / Actively At Work**
   means an **employee** is performing all of the duties of the job with an **employer** for a minimum of 30 hours per week. An **employee** will be considered **actively at work** on:

   a. any scheduled work day he is performing his regular duties for the **employer** at the **employer's** place of business or a location where his **employer** requires him to travel;

   b. any day of a paid vacation; or

   c. any regularly scheduled non-working day, provided that the **employee** was at work on the last regular working day prior to that date.

2. **Activities of Daily Living**

   include, but are not limited to:

   a. Bathing: the ability to wash in a tub, shower or by a sponge bath, with or without the aid of equipment.

   b. Dressing: the ability to put on and take off all garments usually worn, including any **medically necessary orthotic devices** or **prosthetic devices**, and to fasten and unfasten them.

   c. Eating: the ability to consume food by any means once it has been prepared and made available.

   d. Toileting: the ability to get to and from the toilet, get on and off the toilet and to maintain a reasonable level of personal hygiene, all with or without the aid of equipment.

   e. Transferring: the ability to move to and from a bed, chair or wheelchair with or without the aid of mechanical or support equipment.

3. **Admission**

   means the acceptance of a patient into a **hospital** or other facility for **inpatient** care.

4. **Allowable Expense**

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

   The following are examples of charges that are not **allowable expenses**:

   a. the difference between the cost of a semiprivate **hospital** room and a private **hospital** room is not an **allowable expense**, unless one of the **plans** provides coverage for private **hospital** room expenses;

   b. if a person is covered by two or more **plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit is not an **allowable expense**;

   c. if a person is covered by two or more **plans** that provide **benefits** or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an **allowable expense**;

   d. if a person is covered by one **plan** that calculates its **benefits** or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and by another **plan** that provides its **benefits** or services on the basis of negotiated fees, the primary **plan's** payment arrangement shall be the **allowable expense** for all **plans**. However, if the **provider** has contracted with the secondary **plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary **plan's** payment arrangement and if the **provider's** contract permits, that negotiated fee or payment shall be the **allowable expense** used by the secondary **plan** to determine its **benefits**;

e. dental care, vision care, or hearing aids; or

f. the amount of the reduction by the primary **plan** because a **covered person** has failed to comply with the **plan** provisions is not an **allowable expense**. This includes but is not limited to second **surgical** opinions, pre-certification of **admissions** and preferred **provider** arrangements.

5. **Authorized representative**

means the person designated by a **covered person** to contact **us** regarding a **grievance**. The designation must be in writing, specifically authorize contact with **us** regarding a **grievance** and be signed by the **covered person**.

6. **Beneficiary**

means the **covered person's spouse**, mother, father, child or children, brothers or sisters, or executor or administrator of the **covered person's** estate.

7. **Benefits**

means the amount payable for **medically necessary** treatments, services and supplies that qualify for coverage under the **policy**. **Deductibles**, **coinsurance**, **copayments** and pre-certification penalties are subtracted from the **covered expense** to determine the **benefits** payable.

8. **Birthing Center**

means a licensed facility that allows **covered persons** to give birth in a home-like setting.

9. **Calendar Year**

means the period of time which begins at 12:01 a.m. Central Standard Time on January 1st and ends at midnight on the following December 31st. When a person first becomes a **covered person**, the first **calendar year** begins on the effective date of coverage and ends the following December 31st.

10. **Chemical Dependency**

means a condition with physical or psychological symptoms produced by the habitual use of certain drugs or alcohol as described in the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association that is most current at the time the **chemical dependency** is diagnosed**. Chemical dependency** does not include a diagnosis of alcohol abuse, drug abuse or chemical abuse.

11. **Chemical Dependency Treatment Facility**

means a facility that:

a. mainly provides a program for diagnosis, evaluation, and effective treatment of **chemical dependency**; and

b. is located in the **covered person's** state of residence; and

c. meets licensing standards; and

d. prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**; and

e. provides, on the premises, 24 hours a day:

i. detoxification services needed with its effective treatment program; and

ii. infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required; and

iii. supervision by a staff of **physicians**; and

iv. **skilled nursing care** by nurses who are under the **direct supervision** of a full-time registered nurse.

12. **Close Relative**

means:

a. **spouse**;

b. **covered person's** child, brother, sister, or parent; and/or

c. **covered person's spouse's** child, brother, sister or parent.

13. **Closed Panel Plan**

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

14. **COB**

means coordination of benefits.

15. **COBRA**

means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an **employer** can offer continuation of group health insurance to **covered persons** whose coverage would otherwise terminate under the terms of the **policy**.

16. **Coinsurance**

See **Schedule** of Benefits.

17. **Congenital Defect**

means an illness, disorder, malformation or abnormality that was present from the moment of birth, or which has been diagnosed or treated during the growth and developmental process before five years of age. A **congenital defect** is a condition that interferes with bodily functions.

18. **Copayment**

See **Schedule** of Benefits.

19. **Cosmetic Surgery**

means any **surgery** done primarily to improve or change the way one appears. **Cosmetic surgery** does not primarily improve the way the body works or correct deformities resulting from **illness or injury** or **congenital defect** that do not cause functional impairment. **Cosmetic surgery** includes **surgery** to treat a mental, emotional or personality disorder through changes in appearance or body form. It does not include **surgery** that meets the definition of **reconstructive surgery**.

20. **Covered Employee**

means an **employee** who is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

21. **Covered Expense**

means the **reasonable and customary charge** made by a **provider** for **covered services**. A charge is considered to be made at the time a **covered service** is received by the **covered person** even if it was ordered at an earlier date.

22. **Covered person** or **Covered persons**

means an **employee** or **dependent** that is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

23. **Covered Services**

means those **medically necessary** treatments, services, or supplies covered by the **policy**.

24. **Creditable Coverage**

means coverage a **covered person** had under any of the following:

a. a group health **plan**;

b. health insurance coverage for medical care under any **hospital** or medical service policy or HMO contract offered by a health insurance issuer;

c. **Medicare** (Part A or B of Title XVIII of the Social Security Act);

d. **Medicaid** (Title XIX of the Social Security Act);

e. TRICARE (Title X U.S.C. Chapter 55);

f. a medical care program of the Indian Health Service or of a tribal organization;

g. a State health benefits risk pool;

h. the Federal Employees Health Benefits Program;

i. a public health plan established or maintained by a state, the U.S. Government, a foreign country or any political subdivision of a state, the U.S. Government or a foreign country that provides health coverage to individuals who are enrolled in the plan.

j. a health benefit plan under Section 5(e) of the Peace Corps Act;

k. an organized delivery system licensed by the director of public health;

l. a short-term limited duration policy; or

m. State Children's Health Insurance Program (Title XXI of the Social Security Act).

25. **Custodial Care** or **Custodial Services**

means any of the following:

a. care provided when a **covered person** no longer requires the use of **skilled nursing care**, since the **covered person's** condition has improved or stabilized sufficiently;

b. care which is primarily protective or intended to maintain a good level of personal hygiene and nutrition with help in the **activities of daily living**;

c. care provided to **covered persons** who require long term institutional care in a minimal care facility (not requiring **skilled nursing care**);

d. care creating conditions that are being controlled or supervised by structured behavioral modification programs or custodial milieu controlled environmental situations;

e. the provision of room and board (with or without routine nursing care or training in **activities of daily living**) and supervisory care by a **physician** for a **covered person** who may or may not be mentally or physically **disabled** but whose care could have been adequately and safely provided on an **outpatient** basis;

f. the provision of room and board (with or without routine **nursing care** or training in **activities of daily living**), and supervisory care by a **physician** for a **covered person** who may or may not be mentally or physically **disabled** and who is not under specific medical, **surgical** or psychiatric treatment which is likely to reduce the **disability** or enable the **covered person** to live outside an institution providing medical care; or

g. care provided to meet the **covered person's** personal needs or maintain a level of function as opposed to improving that function to allow for a more independent existence.

26. **Custodial Parent**

means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than 1/2 of the **calendar year** without regard to any temporary visitation.

27. **Day Treatment**

means a partial confinement treatment program given to a **covered person** during the day. There is no room charge made by the **hospital** or treatment facility. A **day treatment** program must be for at least:

a. 4 hours in a row during the day; and

b. 5 days a week.

28. **Deductible**

See **Schedule** of Benefits.

29. **Dependent** or **Dependents**

means the following:

a. the **covered employee's spouse**;

b. the **covered employee's** natural or legally adopted child (under age 26);

c. a child (under age 26) for whom the **covered employee** or his **spouse** is the **legal guardian**;

d. a step-child (under age 26) of the **covered employee**;

e. a child (under age 26) covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against a **covered employee** or the **covered employee's spouse**; or

f. a disabled **dependent**. A disabled **dependent** is someone who:

i. is a child under 29.b. or 29.c. or 29.d or 29.e above; and

ii. is age 26 or older; and

iii. is "disabled" which means they are incapable of self-sustaining employment by reason of mental retardation, **mental illness**, or physical handicap; and

iv. obtains the majority of his financial support from the **covered employee** or the **covered employee's spouse**; and

v. was "disabled" prior to age 26.

Disability does not include pregnancy. The **covered employee** must give **us** a written request for coverage of a disabled **dependent**. The request must include written proof that the **dependent** is "disabled" and must be approved by **us** in writing. **We** must receive the proof of disability within 31 days of the date an already enrolled **dependent** becomes eligible for coverage under this definition or when adding a **dependent** eligible under this definition. **We** reserve the right to periodically review the disability status of the **dependent**. After the first two years, **we** will not review the disability more frequently than once every **calendar year**.

A person who is a **covered employee** is not eligible as a **dependent** under any **policy** issued by **us**. No one can be considered a **dependent** of more than one **covered employee** under any **policy** issued by **us**. If both **spouses** are covered as **covered employees** under any **policy** issued by **us**, only one **spouse** shall be considered to have any eligible **dependents**.

30. **Diabetes Education Program**

means a state-certified, **outpatient** education program. The program helps any type of diabetic and his family understand the diabetes disease process, nutritional therapy and the daily management of diabetes.

31. **Direct Supervision**

means the supervising person is physically present and immediately available through the same office more than 50% of each day when the supervised person is providing services.

32. **Disabled** or **Disability**

a. An **employee** will be considered **disabled** if because of an **illness** or **injury**:

i. he is unable to perform the basic duties of his occupation; and

ii. he is not performing any work or engaging in any other occupation for wage or profit; and

iii. he is under the regular care of his **physician**.

b. A **dependent** will be considered **disabled** if because of an **illness** or **injury**:

i. he is unable to engage in the normal activities of a person of the same age, sex and ability; and

ii. he is under the regular care of his **physician**; and

iii. in the case of a **dependent** who normally works for wage or profit:

(1) he is not performing such work; and

(2) he is unable to perform the basic duties of his occupation.

33. **Durable Medical Equipment**

means equipment that is:

a. designed for and able to withstand repeated use; and

b. primarily and customarily used to serve a medical purpose; and

c. generally is not useful in the absence of an **illness** or **injury**; and

d. suitable for use at home.

34. **Emergency Admission**

means one where the **physician** admits the **covered person** to the **hospital** right after the sudden and, at that time, unexpected onset of a change in the **covered person's** physical or mental condition:

a. which requires immediate confinement as an **inpatient**; and

b. if immediate **inpatient** care was not given, could reasonably be expected to result in an **emergency condition**.

35. **Emergency Care**

means the treatment given to evaluate and treat **emergency conditions** or **illness** or **injury** in an emergency room or emergency facility.

36. **Emergency Care Visit**

means an examination by a **physician** in an emergency room or emergency facility that includes:

a. history;

b. examination;

c. medical decision making; and

d. coordination of care.

Emergency care visit does not include examination by a **physician** for **mental illness** or **chemical dependency**.

37. **Emergency Condition**

means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his condition, **illness** or **injury** is of such a nature that failure to get immediate medical care could result in:

a. placing the person's health in serious jeopardy;

b. serious impairment to bodily function;

c. serious dysfunction of a body part or organ; or

d. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

38. **Employee**

means someone who is **actively at work** in an **employer's** business. **Employee** does not include owners, shareholders or officers of the business who are not **actively at work** in the business. The **employee** must be reasonably compensated and his **employer** must report his earnings as required for Social Security. Temporary employees, consultants, advisors and other similar individuals do not qualify as **employees**.

39. **Employer**

means an **employer** who, in order to provide group health coverage to eligible **employees**, purchased the **policy** or participates in a multiple employer trust that purchased the **policy**.

40. **Enrollment Date**

means the date a **covered person's** coverage under the **policy** is effective, or, if earlier, the first day of the **waiting period** for such enrollment. For a **late enrollee** or anyone who enrolls during a special enrollment period, **enrollment date** means the effective date of coverage under the **policy**.

41. **Experimental** or **Investigational**

means a drug, device, medical treatment or procedure which:

a. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use;

b. is the subject of a current investigational new drug or new device application on file with the FDA;

c. is being provided pursuant to:

i. a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or

ii. a written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives;

d. is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS);

e. in the predominant opinion among experts:

i. as expressed in the published, authoritative literature, is substantially confined to use in research settings;

ii. is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or

iii. is experimental, investigational, unproven or is not a generally acceptable medical practice;

f. is not a covered service under **Medicare** because it is considered investigational or experimental as determined by the Department of Health and Human Services; or

g. is provided concurrent with treatment, procedure, device or drug which is experimental, investigational, unproven treatment; or

h. has not been performed at least ten (10) times and reported on in United States peer review medical literature.

42. **Facility Fee**

means the charge (other than room and board) made by an institutional health care provider for use of their premises that is in addition to the professional fee charged by the **physician**.

43. **Grievance**

means any dissatisfaction with the administration or claims practices of or provision of service by **us** which is expressed in writing by or on behalf of a **covered person**.

44. **Health Status Related Factor**

means any of the following:

a. health status;

b. medical condition (including both a physical and mental condition);

c. claims experience;

d. receipt of health care;

e. medical history;

f. genetic information;

g. evidence of insurability (including conditions arising out of acts of domestic violence); or

h. disability.

45. **Home Health Care Agency**

means an entity that:

a. provides **skilled nursing care** and other therapeutic services; and

b. is associated with a professional group having at least one **physician** and one nurse; and

c. has full time supervision by a **physician** or nurse; and

d. keeps complete medical records on each patient; and

e. has a full time administrator; and

f. meets licensing standards for the state where it operates.

46. **Home Health Care**

means services provided to a **covered person** in his home by a **home health care agency** under a plan of care approved in writing by **us** before services begin.

47. **Hospice Agency**

means an entity that provides medical services and counseling to a terminally ill person. The entity must meet all of the following tests:

a. it has obtained any required state or governmental Certificate of Need approval;

b. it provides service 24 hours a day, 7 days a week;

c. it is under the **direct supervision** of a **physician**;

d. it is an agency that has as its primary purpose the provision of hospice services;

e. it has a full- time administrator;

f. it maintains written records of services provided to the **covered person**; and

g. it is licensed as a hospice, if licensing is required by the state where it operates.

48. **Hospital**

means a facility that:

a. is duly licensed as a **hospital** and operating within the scope of such license under the laws of the governing jurisdiction; and

b. it is not a **nursing facility**; and

c. it is not, other than incidentally:

i. a place for **custodial care**;

ii. a place for the aged;

iii. a place of rest; or

iv. a nursing home, a hotel, or a similar facility.

49. **Illness or Injury**

means any bodily disorder, disease, **mental illness** or bodily injury. This includes pregnancy.

50. **Incremental Nursing**

means charges for nursing services in addition to the normal nursing charge associated with **inpatient** room and board charges.

51. **Inpatient**

means that the treatment, services or supplies are furnished to a **covered person** while the **covered person** is confined in a **hospital** or other facility as a registered bed patient. Any confinement for observation that exceeds 24 hours is considered to be **inpatient**.

52. **Intensive Care Unit**

means a special room or area in a **hospital** which includes:

a. beds in a distinctly identifiable unit that are used only for critically ill or injured patients;

b. a separate nursing staff; and

c. special supplies and equipment needed to care for critically ill or injured patients.

Medically necessary isolation rooms will be considered part of an **intensive care unit**.

53. **Late Enrollee**

means a person who applies for coverage under the **policy** other than:

a. when he is first eligible; or

b. during a special enrollment period.

54. **Legal Guardian**

means the person appointed by a court of competent jurisdiction who has been granted sole authority to provide for the medical care of another. **We** may demand production of legal orders or other documents sufficient to establish proof of legal guardianship.

55. **Lifetime Maximum**

means the total **benefit** payable by **us** during the **covered person's** lifetime through coverage provided by the **employee's** current **employer**. The **lifetime maximum** does not include amounts that are the **covered person's** responsibility such as **deductibles**, **coinsurance**, **copayments**, pre-certification penalties, and other amounts. Exceeding the **lifetime maximum** does not trigger any conversion or continuation right under the **policy**.

56. **Maintenance Care**

means treatment, services or supplies that are provided solely to keep the **covered person's** condition at the level to which it has been restored, even if the **covered person** is in a **hospital** or other facility. **Maintenance care** includes treatment, services or supplies provided to:

a. maintain a level of functioning;

b. prevent disease;

c. promote health;

d. enhance the quality of life;

e. prevent deterioration of a chronic condition; or

f. prevent medical problems from occurring or recurring.

57. **Manipulative Therapy**

means treatment, services or supplies to detect and correct, by manual or mechanical means, a structural distortion of the body in order to remove nerve interference and its effects. Such interference must be the result of or be related to a distortion of the spinal column or the musclo-skeletal structure of the body. This includes but is not limited to disclosures and subluxations of the vertebrae.

58. **Medical Supplies**

means supplies that are:

a. primarily and customarily used to serve a medical purpose; and

b. generally is not useful in the absence of an **illness** or **injury**; and

c. prescribed by a **physician**.

This includes but is not limited to casts, splints, braces, trusses, support stockings, slings, syringes, ostomy supplies (pouches, face plates, belts, irrigation sleeves, bags and skin barriers), catheters, burn garments and surgical dressings. It does not include common first aid supplies.

59. **Medically Necessary / Medical Necessity**

means a treatment, service or supply that **we** determine to be:

a. Necessary for the diagnosis or the direct care and treatment of the **illness** or **injury**; and

b. In accordance with generally accepted medical practice and management currently used in the United States; and

c. The most appropriate level of medical care that is needed to provide safe, adequate and appropriate diagnosis or medical treatment; and

d. Not for convenience purposes; and

e. Not **experimental** or **investigational**; and

f. Not for **maintenance care**.

The fact that a **physician** prescribes, orders, recommends or approves the care, the level of care or the length of time care is to be received, does not make the treatment services or supplies **medically necessary**.

60. **MEDICAID**

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

61. **MEDICARE**

means the program established by Title XVIII of the Social Security Act of 1965 as amended.

62. **Mental Illness**

means a condition that manifests symptoms for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause.

In determining whether or not a particular condition is a **mental illness**, we may refer to the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association that is most current at the time the **mental illness** is diagnosed. Alcoholism, drug addiction or **chemical dependency** are not considered **mental illness**.

63. **Month**

means the period starting at 12:01 a.m. Central Standard Time on the 1st day of a given calendar **month** and ending at midnight on the last day of the calendar **month**.

64. **Network Provider**

means

a. for **Prescription Drugs** (Section VI - **Covered Services**, item 24) **network provider** includes only the prescription drug card program and specialty drug program. **Network provider** does not include any other **provider** or network of **providers** with which **we** contract for other services;

b. for Transplant Services (Section VI - **Covered Services**, item 32), **network provider** includes a **physician**, **hospital** or other **provider** that is currently a participating member of a network of transplant **providers** (regardless of other **network** affiliation) who have agreed with **us** to provide transplant services to **covered persons** at a negotiated rate;

c. for Dialysis Services (Section VI - **Covered Services**, item 8), **network provider** includes a **physician**, **hospital** or other **provider** that is currently a participating member of a network of dialysis **providers** (regardless of other **network** affiliation) who have agreed with **us** to provide dialysis services to **covered persons** at a negotiated rate;

d. for Diagnostic Services - Radiology (Section VI - **Covered Services**, item 7), **network provider** includes a **physician**, **hospital** or other **provider** that is currently a participating member of a network of radiology **providers** (regardless of other **network** affiliation) who have agreed with **us** to provide radiology services to **covered persons** at a negotiated rate; and

e. for **covered services** not listed above **network provider** is a **physician**, **hospital** or other **provider** that is currently a participating member of a network **providers** who have agreed with **us** to provide services to **covered persons** at a negotiated rate.

65. **Never Events**

means

a. **surgery** or other invasive procedure performed on the wrong site;

b. **surgery** or other invasive procedure performed on the wrong patient;

c. wrong **surgical** procedure or other invasive procedure performed on a **covered person**;

d. unintended retention of a foreign object in a **covered person** after **surgery** or other invasive procedure;

e. intraoperative or immediately postoperative/postprocedure death in a ASA Class 1 patient (normal health patient);

f. death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting;

g. death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;

h. death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility;

i. discharge or release of a **covered person** of any age, who is unable to make decisions, to other than an authorized person;

j. death or serious injury associated with the **covered person's** elopement (disappearance);

k. suicide, or attempted suicide, while being cared for in a healthcare setting;

l. death or serious injury associated with a medication error;

m. death or serious injury associated with unsafe administration of blood products;

n. maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting;

o. death or serious injury associated with a fall during or after being cared for and prior to leaving the grounds of a healthcare setting;

p. any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting;

q. artificial insemination with the wrong donor sperm or wrong egg;

r. death or serious injury resulting from the irretrievable loss of biological specimen;

s. death or serious injury resulting from failure to follow up or communicate clinical information;

t. death or serious injury associated with an electronic shock in the course of a patient care process in a healthcare setting;

u. any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances;

v. death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting;

w. death or serious injury associated with the use of physical restraints or bedrails while being care for in a healthcare setting;

x. death or serious injury of a **covered person** associated with the introduction of a metallic object into the MRI area; and

y. any instance of care ordered by or provided by someone impersonating a **physician**, nurse, pharmacist, or other licensed healthcare **provider**.

66. **Non-Network Provider**

means a

a. **provider** that is not a **network provider**.

b. for **prescription drugs**, **non-network provider** means any **provider** (regardless of other network affiliation) other than the **prescription drug** card program or specialty drug program.

67. **Nurse Midwife**

means a person who:

a. is licensed to practice as a **nurse midwife**; and

b. is practicing within the scope of the license in his state.

68. **Nursing Facility**

means a facility:

a. that is duly licensed as a **nursing facility** or a skilled **nursing facility**; and

b. is operating within the scope of such license under the laws of the state where it operates.

69. **Occupational Therapy**

means constructive therapeutic activity designed or adapted to promote the restoration of useful physical function lost or impaired as a result of **illness** or **injury**. It includes relearning daily living skills or compensatory techniques. **Occupational therapy** does not include educational training or other services designed or adapted to develop a physical function and testing or training related to learning disabilities or developmental delays or delayed motor development.

70. **Office Visit**

means an examination by a **physician** in his office or an **urgent care** center that includes:

a. history;

b. examination;

c. medical decision making; and

d. coordination of care.

Office visit does not include examination by a **physician** for **mental illness** or **chemical dependency**. **Office visit** does not include **facility fees**.

71. **Orthotic Device**

means rigid and semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. **Orthotic devices** do not include shoes, elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items. **Orthotic devices** include individualized custom fabricated shoe inserts.

72. **Outpatient**

means that the treatment and services or supplies are furnished to a **covered person** while the **covered person** is not confined in a **hospital** or facility as a registered bed patient.

73. **Out-of-pocket Maximum**

See Schedule of Benefits.

74. **Physical Therapy**

means the treatment of **illness** or **injury** by physical means which is designed or adapted to promote the restoration of a useful physical function. **Physical therapy** does not include educational training or other services designed or adapted to develop a physical function and testing or training related to learning disabilities or developmental delays or delayed motor development.

75. **Physician**
means a licensed medical doctor. For **mental illness** services, **physician** includes a licensed psychologist. When **we** are required by law to cover the services of any other licensed medical professional under the **policy**, a **physician** also includes such other licensed medical professional who:

a. is acting within the lawful scope of his license; and

b. performs a service that is covered by the **policy**.

76. **Plan**

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

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

b. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage, benefits for non-medical components of long-term care policies; **Medicare** supplement policies, **Medicaid** policies and coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate **plan**. If a **plan** has two parts and **COB** rules apply only to one of the two, each of the parts is treated as a separate **plan**.

77. **Policy**

means policy forms, amendments and riders that constitute the agreement regarding the **benefits**, exclusions and other conditions.

78. **Pre-existing Condition**

means an **illness** or **injury** or related condition for which medical advice, diagnosis, care or treatment was recommended by a **physician** or received within the 6 consecutive **months** ending on the **enrollment date**.

79. **Prescription Drug**

means a drug, or a compound containing a drug, which under state or federal law may be dispensed only on the prescription of a **physician**. The term **prescription drug** also includes a placebo and injectable insulin.

80. **Prosthetic Device** or **Prostheses**

means a device which replaces all or part of an absent body part (including contiguous tissue). It also includes a device which replaces all or part of the function of a permanently inoperative or malfunctioning body organ.

81. **Provider**

A **physician**, **hospital**, **nursing facility**, treatment facility, pharmacy or other health care facility or practitioner, properly licensed, certified or otherwise authorized pursuant to the law of jurisdiction in which care or treatment is received.

82. **Reasonable and Customary Charges**

means the ″most common charge″ for similar services, drugs, procedures, devices, supplies or treatment within the ″geographic area″ in which the charge is incurred, so long as those charges are reasonable.

a. The ″most common charge″ means the lesser of:

i. the actual amount charged by the **provider**;

ii. the negotiated rate; or

iii. the charge which would have been made by other **providers** for comparable services, drugs, procedures, devices, supplies or treatment in the same geographic area, as reasonably determined by **us** for the same services, drugs, procedures, devices, supplies or treatment.

b. For **prescription drugs** the "most common charge" is the lesser of:

i. the actual amount charged by the **provider**;

ii. the negotiated rate; or

iii. the average wholesale price from a nationally recognized pharmaceutical pricing guide.

c. "Geographic area" means:

i. the three digit zip code in which the services, drugs, procedures, devices, supplies or treatment are provided; or

ii. a greater area if necessary, to obtain a representative cross-section of charges for like services, drugs, procedures, devices, supplies or treatment.

d. In determining whether a charge is reasonable, **we** may consider such factors as **we**, in the reasonable exercise of our discretion, determine are appropriate, including but not limited to:

i. The complexity of the service, drug, procedure, device, supply or treatment involved; or

ii. The degree of professional skill, experience and training required for a **physician** to perform the procedure or service;

iii. The severity or nature of the **illness** or **injury** being treated;

iv. The **provider's** adherence or failure to adhere to charging and practices generally accepted by an established United States medical society as determined by **us**; or

v. The cost of the **provider** of providing the services or supplies, or performing the procedure.

83. **Reconstructive Surgery**

means **surgery** that primarily restores bodily function or corrects deformity that causes functional impairment. This **surgery** is needed as a result of **illness** or **injury**, **congenital defects**, or previous therapeutic processes. **Reconstructive surgery** would not be considered **cosmetic surgery**.

84. **Residential Treatment Facility**

means a residential or non-residential facility or program licensed, certified or otherwise authorized to provide treatment of **chemical dependency** located in the the **covered person's** state of residence.

85. **Schedule**

means the Schedule of Benefits attached to the **policy**.

86. **Serious Mental Illness** or **Biologically Based Mental Illness**

means:

a. schizophrenia;

b. schizo-affective disorder;

c. bipolar disorder;

d. obsessive-compulsive disorder;

e. panic disorder;

f. major depressive disorder;

g. pervasive developmental disorders; or

h. autistic spectrum disorder.

87. **Skilled Nursing Care** or **Skilled Nursing Services**

means care or services provided by licensed nurses under the **direct supervision** of a registered nurse or **physician**.

88. **Sound Natural Teeth**

means a **covered person's** own tooth restored to function. This includes teeth with fillings or crowns but does not include bridgework or dentures.

89. **Speech Therapy**

means the treatment for the restoration of speech lost or impaired as a result of **illness** or **injury**, **congenital defects** or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. **Speech therapy** does not include educational training or services designed or adapted to develop a physical function and testing or training related to learning disabilities or developmental delays or delayed motor development.

90. **Spouse**

means a person legally married to a **covered person**.

91. **Surgery** or **Surgical** or **Surgical Procedure**

means procedures listed as **surgery** in the edition of the American Medical Association Current Procedural Terminology (CPT) book most current at the time of the **surgery**. This includes but is not limited to cutting into the skin, repairing wounds (stitches), repair and casting of broken bones, removal of skin lesions and warts, nerve block injections and injections into a joint.

92. **Urgent Care**

means treatment, services or supplies received at a facility that meets professionally recognized standards as follows:

a. it mainly provides urgent or emergency medical treatment for acute conditions;

b. it does not provide services or accommodations for overnight stays;

c. it has on duty at all times a **physician** trained in emergency medicine and nurses and other supporting personnel who are specially trained;

d. it has x-ray and laboratory diagnostic facilities, emergency equipment, trays, and supplies for use in life threatening events;

e. it complies with all licensing and other legal requirements; and

f. it is not an emergency room.

93. **Waiting Period**

means the period of time that must pass before an **employee** or **dependent** is eligible for coverage under the **policy**.

94. **Workers' Compensation**

means insurance benefits mandated under state Workers' Compensation laws.

SECTION IX - **GRIEVANCE** AND APPEAL PROCEDURES

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions.

1. SUBMISSION OF **GRIEVANCES**

   Initial grievances based on **our** utilization review organization's (named on the back of the identification card provided to **covered persons**) denial of a pre-certification request under Section I - General Provisions, 16. Pre-Certification Requirements should be submitted to the utilization review organization as directed in their non-certification letter. All other initial **grievances** should be submitted to **our** Medical Benefits & Services Appeals Department at:

   Medical Benefits & Services Appeals
   Federated Mutual Insurance Company
   P.O. Box 328
   Owatonna, MN 55060

   After that first review is completed, a second level **grievance** can be submitted to **our** Medical Benefits & Services Appeals Department. A **covered person** can also contact the local U.S. Department of Labor Office or insurance regulator in their state to submit a **grievance** or complaint.

   A **covered person** can appoint an **authorized representative** to act on his behalf in pursuing a **grievance**. Except for a **grievance** related to an **emergency condition**, the appointment of an **authorized representative** for handling **grievances** must be in writing and signed by the **covered person**. An assignment of benefits to a **provider** is not appointment of an **authorized representative** for **grievances**.

   Initial **grievances** must be submitted within 180 calendar days of the event giving rise to the **grievance**. The event giving rise to the **grievance** can be a notice of **benefit** determination, a notice of rescission of coverage, an administrative action by **us** or the provision of another service by **us**. For a **grievance** related to a notice of **benefit** determination or a notice of rescission of coverage, the date of the event is printed on the notice. For a **grievance** related to an administrative action by **us**, the date of the event is the date **we** took the administration action. For a **grievance** related to the provision of another service by **us**, the date of the event is the date **we** provided the service.

   Second level **grievances** must be submitted within 60 calendar days of the date printed on the written notice of the initial **grievance** decision.

2. INITIAL **GRIEVANCE** PROCEDURE

   When an initial **grievance** is received by **our** utilization review organization regarding treatment, services or supplies requiring pre-certification or the Medical Benefits & Services Appeals Department regarding all non-pre-certification issues, the following procedure will be used.

   a. Written acknowledgment of the **grievance** will be sent to the **covered person** and/or the **authorized representative** within 3 business days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit additional written material.

   b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.

   c. If the issue is clinical, the reviewer will consult a **physician** who was not involved in the initial review of the matter.

   d. The **covered person** will be provided with copies of any new or additional evidence or rationale considered, relied upon, or generated by **us**, prior to receiving a determination based upon new or additional evidence or rationale.

   e. An investigation will be completed and a decision made within 15 calendar days of receipt for a pre-service claim and within 30 calendar days of receipt for a post-service claim.

   f. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:

      i. the specific reason for the utilization review organization's or **our** decision;

      ii. the specific **policy** provisions applicable to the **grievance**;

      iii. any internal guidelines used in making the decision;

iv. if the decision is based on **medical necessity** or the treatment being **experimental or investigational**, notice that the clinical basis for the decision will be provided on request;

v. information on how to obtain copies of documents the utilization review organization or **we** have on the **grievance**;

vi. information on how to file a second level **grievance** and the right to sue after internal **grievance** procedures are completed by **us**;

vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; or

viii. in states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review.

3. SECOND LEVEL **GRIEVANCE** PROCEDURE

A second level **grievance** on any matter is initiated by sending a request for review to:

Medical Benefits & Services Appeals
Federated Mutual Insurance Company
P.O. Box 328
Owatonna, MN 55060

Or by calling 507-455-5200 or 800-533-0472 and asking for the Medical Benefits & Services Appeals Department.

Our Medical Benefits & Services Appeals Department will complete this review unless the **covered person** exercises their right to appear in person to present the **grievance** to a designated committee when making their written request.

When a second level **grievance** is received by **our** Medical Benefits & Services Appeals Department, the following procedure will be used.

a. Written acknowledgment of the **grievance** will be sent to the **covered person** and/or the **authorized representative** within 3 business days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit additional written material.

b. If the **covered person** exercised the right to appear in person, the **covered person** will receive notice of the date and time to appear before the designated committee at least 7 calendar days in advance of the designated committee meeting date.

c. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.

d. If the issue is clinical, **we** will consult a **physician** who has not previously reviewed the matter.

e. The **covered person** will be provided with copies of any new or additional evidence or rationale considered, relied upon, or generated by **us**, prior to receiving a determination based upon new or additional evidence or rationale.

f. An investigation will be completed and a decision made within 15 calendar days of receipt for a pre-service claim and within 30 calendar days of receipt for a post-service claim.

g. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:

i. the specific reason for **our** decision;

ii. the specific policy provisions applicable to the **grievance**;

iii. any internal guidelines used in making the decision;

iv. if the decision is based on **medical necessity** or the treatment being **experimental or investigational**, notice that the clinical basis for the decision will be provided on request;

v. information on how to obtain copies of documents **we** have on the **grievance**;

vi. information on the right to sue after internal **grievance** procedures are completed by **us**;

vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.";

viii. in states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review; or

ix. information on the right to external review by an independent review organization.

4. EXPEDITED **GRIEVANCE** REVIEW

If the **grievance** relates to an **emergency condition**, an expedited review can be requested. A **covered person**, **authorized representative** or **provider** on behalf of a **covered person** can request expedited review.

If the **covered person**, **authorized representative** or **provider** requests an expedited review, an initial determination will be made within 72 hours of the request. Within 3 business days of the initial determination, the **covered person**, **authorized representative** or **provider** may request further review by **us**. If further review by **us** is requested, the final determination will be made within 30 calendar days. The initial determination and final determination on an expedited **grievance** may be made orally but will be followed up in writing within 2 business days.

5. EXTERNAL REVIEW PROCEDURES

A **covered person** who receives an adverse determination or a final adverse determination from **us** has the right to file a request for an Independent External Review by the Commissioner of the Office of Financial and Insurance Services or by an Independent Review Organization by contacting the Commissioner at:

Office of Financial and Insurance Regulation
Health Plan Division
530 W. Allegan Street
PO Box 30220
Lansing, MI 48909-7720
Toll-free phone number: (877) 999-6442
Website: http://www.michigan.gov/ofir

The request for an Independent External Review must be made by the **covered person** or **authorized representative** or **authorized provider** within 60 calendar days of receipt of notice of an adverse determination or final adverse determination issued after the service was provided to the **covered person.**

A request for an Expedited External Review must be made by the **covered person** or **authorized representative** or authorized **provider** within 10 calendar days of receipt of a notice of an adverse determination if the adverse determination involves a medical condition of the **covered person** for which the completion of an expedited internal **grievance** would seriously jeopardize the life or health of the **covered person** or would jeopardize the **covered person's** ability to regain maximum function as substantiated by a **physician** either orally or in writing and has also filed a request for an expedited internal **grievance** with **us.**

When filing a request of an external review, the **covered person** will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

For purposes of this section, an "adverse determination" means a determination by **us** or **our** designee utilization review organization that an admission, availability of care, continued stay, or other health care services has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

6. RECORDKEEPING

We will maintain a record of all **grievances** filed and their resolution. The record will include the name of the **covered person**, date of the **grievance**, nature of the **grievance**, date of response/resolution and summary of the resolution. Copies of all **grievances**, investigative material and response letters will be kept with the **grievance** record. The **grievance** record will be maintained in the claims office for a minimum of 5 years.

Periodically, **we** will review the **grievance** record. This review will include analysis of the appropriateness of responses.

FEDERATED MUTUAL
INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP HEALTH POLICY AND CERTIFICATE RIDER

RIDER EFFECTIVE DATE: October 15, 2012

The **policy** and certificate are changed as follows for policies issued in Michigan:

1. The following is added to SECTION VI - **COVERED SERVICES**:

33. AUTISM SPECTRUM DISORDERS

a. Coverage is provided for the "diagnosis of autism spectrum disorders" and "treatment of autism spectrum disorders" for **covered persons**. Coverage for "behavioral health treatment" of "autism spectrum disorders" including "applied behavior analysis" not otherwise covered by the **policy** is limited to the following maximum annual **benefit** limits through 18 years of age:

i. $50,000 for a **covered person** through 6 years of age.

ii. $40,000 for a **covered person** from 7 years of age through 12 years of age.

iii. $30,000 for a **covered person** from 13 years of age through 18 years of age.

b. Coverage is limited to **medically necessary** treatment ordered by a board certified or licensed provider in a "treatment plan" subject to the following conditions:

i. Upon request, **we** may require a review of the "treatment plan" consistent with current protocols. If requested by **us**, the cost of the treatment review will be paid by **us**.

ii. Upon **our** request the **provider** shall furnish to **us** the "autism diagnostic observation schedule" that has been used in the diagnosis of an "autism spectrum disorder." **We** may request that the "autism schedule observation schedule" be performed on that **covered person** not more frequently than once every 3 years.

iii. Upon **our** request the **provider** shall conduct an annual developmental evaluation and submit the results to **us**.

c. The following definitions apply to this coverage:

i. "Applied behavior analysis," means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

ii. "Autism diagnostic observation schedule" means the protocol available through Western Psychological Services for diagnosing and assessing "autism spectrum disorders" or any other standardized diagnostic measure for "autism spectrum disorders" that is approved by the Michigan Commissioner of Insurance, if the Commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

iii. "Autism spectrum disorder" means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual;

(1) Autistic disorder;

(2) Asperger's disorder; and

(3) Pervasive developmental disorder not otherwise specified.

iv. ″Behavioral health treatment″ means evidenced-based counseling and treatment programs, including ″applied behavior analysis″ that meet both of the following requirements:

(1) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of a **covered person**.

(2) Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experiences.

v. ″Diagnosis of autism spectrum disorders″ means assessments, evaluations, or tests including the ″autism diagnostic observation schedule,″ performed by a licensed **physician** or a licensed psychologist to diagnose whether a **covered person** has one of the ″autism spectrum disorders.″

vi. ″Treatment of autism spectrum disorders″ means evidence-based treatment that includes the following care prescribed or ordered for a **covered person** diagnosed with one of the ″autism spectrum disorders″ by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**:

(1) ″Behavioral health treatment″;

(2) Pharmacy care;

(3) Psychiatric care;

(4) Psychological care; and

(5) Therapeutic care.

vii. ″Treatment plan″ means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

2. SECTION VII - EXCLUSIONS, item 24.I. ″Lovaas therapy or applied behavioral analysis.″ is deleted.

SECRETARY **PRESIDENT**

THE FOLLOWING PAGES

PROVIDE ADDITIONAL

INFORMATION

ABOUT YOUR HEALTH PLAN

SUMMARY PLAN DESCRIPTION

LIVONIA AUTOMOTIVE SALES & SER EMPLOYEE SECURITY BENEFITS PLAN

Purpose of SPD

This Summary Plan Description ("SPD") is a simplified description of the LIVONIA AUTOMOTIVE SALES & SER Employee Security Benefits Plan ("Plan"). The benefits offered under this Plan are insured and are governed solely by the terms of the Policy. For information about Plan benefits, refer to the Certificate of Insurance Coverage provided to you by the Insurer.

This summary is not meant to extend or change the provisions of the Plan or the benefits provided under the Plan in any way.

Plan Name and Number

The name of the Plan is the LIVONIA AUTOMOTIVE SALES & SER Employee Security Benefits Plan. The Plan number is 9303 .

Employer/Plan Sponsor's Name, Address, and Employer Identification Number [EIN]

LIVONIA AUTOMOTIVE SALES & SER ("the Company") is the Plan Sponsor of the Plan and the employer whose Eligible Employees are covered under the Plan. The address, telephone number, and EIN for the Company are:

LIVONIA AUTOMOTIVE SALES & SER
30777 PLYMOUTH RD
LIVONIA MI 48150
(734) 525-5000
38-2245869

Plan Administrator's Name, Address, Telephone Number and Discretionary Authority

The Company is the Plan Administrator of the Plan. The address and telephone number for the Company are stated above.

Subject to the Insurer's absolute discretionary power and authority with respect to interpretation and administration of the Policy, the Plan Administrator has absolute discretionary power and authority with respect to interpretation and administration of the Plan.

Insurer's Name, Address, Telephone Number and Discretionary Authority

The name, address and telephone number for the Insurer are:

Federated Insurance Companies
121 East Park Square, Owatonna, MN 55060
(507) 455-5200

The Insurer has absolute discretionary power and authority with respect to interpretation and administration of the Policy, including payment of claims. Claims procedures will be furnished automatically, without charge as a separate document.

Type of Plan

The plan is an employee welfare benefit plan that provides fully insured group health benefits. All benefits are provided by the insurer under the terms of a policy of insurance (the "Policy"). The benefits are described in the Certificate of Insurance Coverage, which is a separate document prepared by the insurer that provides detailed information about the Policy.

Plan Year

The Plan Year is the 12-month period beginning each December 1 .

Eligibility for Participation in the Plan

You are eligible to participate in the Plan if you are an Eligible Employee. You are an Eligible Employee if:

(i) the Company considers you to be a current employee; and

(ii) you are regularly scheduled to work at least 30 hours per week (or, if you are employed in Ohio by an employer with 50 or fewer employees, 25 hours per week; or if you are employed in Oklahoma by an employer with 50 or fewer employees, 24 hours per week).

You can elect coverage for your Dependents, who are your spouse and children (including any foster children) under age 26. Certain disabled children may be covered after age 26. See the Certificate of Insurance Coverage for more details.

If you are reclassified as an Eligible Employee by a court, administrative body, or the Company, the reclassification will be effective only on a prospective basis.

Enrollment in Benefits

To be eligible to receive benefits, you must complete enrollment forms in the manner prescribed by the Insurer. In general, you may enroll in coverage:

- when you are first eligible to participate; and,
- if you have an HIPAA special enrollment right as a result of a loss of coverage, your marriage, the birth of your child, the adoption of your child or the placement of a child with you for adoption.

You may enroll in coverage at other times if the Policy permits.

Please refer to the Certificate of Insurance Coverage for information regarding when enrollment can occur.

Policy Determines Coverage and Benefits

The terms and conditions of the Policy will determine the terms and condition of coverage and benefits under the Plan, including:

- eligibility requirements for coverage;
- commencement and termination of coverage;
- ability to continue participation during a leave of absence;
- type of benefits provided;
- deductibles, co-insurance, co-payments, and benefit maximums;
- the amount of benefits to which a covered person will be eligible;
- restrictions, limitations and conditions of coverage and benefits;
- procedure for filing a claim, including time periods within which claims must be filed, and the appeal procedure for a denied claim;
- coverage continuation and conversion rights, if any; and
- the Plan's reimbursement and subrogation rights, if any.

Please refer to the Certificate of Insurance Coverage for more information.

Contributions for Premiums

Premiums for the coverages you elect are paid through your contributions and contributions by your employer. You will be informed what premium amount you will be required to pay.

Plan Amendment and Termination

The Company reserves the right to amend or terminate the Plan at any time. An amendment or termination will be in writing and will be signed by an officer of the Company.

The Insurer has the right to amend or terminate the Policy.

QMCSO Procedures

The Plan Administrator will determine whether an order requiring the Plan to add a child to group health coverage is a Qualified Medical Child Support Order. You can obtain a copy of the QMCSO procedures upon request and free of charge from the Plan Administrator.

Legal Process

Legal Process can be served on the Plan Administrator, at the address provided on Page one (1) of this document.

No Employment Guarantee

Participation in this Plan does not constitute a contract of initial or continued employment.

Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and, for employers with more than 100 participants, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and, for employers with more than 100 participants, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- For employers with more than 100 participants, receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Certificate of Insurance Coverage to determine whether the Plan provides continuation coverage rights and whether you would be eligible for continuation coverage.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-existing Conditions

You have the right to the reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan; if the plan provides continuation coverage, when you become entitled to elect such continuation coverage or when your continuation coverage ceases; if you request a certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion. Review the Certificate of Insurance Coverage for information on pre-existing condition exclusions.

Certificate of Creditable Coverage

You have the right to request a certificate of creditable coverage at any time while you are covered under the plan and up to 24 months after coverage ceases. We will provide your certificate in writing 14 business days following receipt of your request by Federated Mutual Insurance Company at the address or phone number listed on the first page of this document.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

STATEMENT OF RIGHTS UNDER THE NEWBORNS′ AND MOTHERS′ HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother′s or newborn′s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact your plan administrator (your employer) for more information. To obtain a copy of the Department of Labor's publication, Your Rights After a Mastectomy, contact their Employee Benefit Security Administration toll free at 866-444-3272.

FEDERATED INSURANCE®

NOTICE OF PRIVACY PRACTICES
FEDERATED MUTUAL INSURANCE COMPANY
HEALTH INSURANCE DIVISION

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review this notice carefully.

YOUR RIGHTS. When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of the request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say ″no″ to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say ″yes″ if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to share or use certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say ″no″ if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but we may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

YOUR RIGHTS (continued)

File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by using the contact information at the end of this notice. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to: 200 Independence Ave., SW, Washington, D.C. 20201. • We will not retaliate against you for filing a complaint.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, tell us and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster or relief situation • Contact you for fundraising efforts

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we think it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission	• Marketing purposes • Sale of your information

OUR USES AND DISCLOSURES. How do we use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	• *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary.	• *Example: We use health information to develop better services for you.*

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *This does not apply to long-term care plans.*

OUR USES AND DISCLOSURES (continued)

Pay for your health services	• We can use and disclose your health information as we pay for your health services.	• *Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	• *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Additional information

- If your state has more stringent laws that apply to your health information, we will comply with those state laws.
- We never market or sell your health information.

OUR RESPONSIBILITIES.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

CONTACT INFORMATION

If you would like general information about your privacy rights or would like a copy of this notice, go to: http://www.federatedinsurance.com. If you have specific questions about your rights or about this notice, you may contact us:

- Call us at the toll-free number on the back of your member identification card and ask to speak to the Privacy Officer.
- Call us at 1-507-455-5200 or 800-533-0472 and ask to speak to the Privacy Officer.
- Write us at:

Federated Mutual Insurance Company
Attn: Privacy Officer
121 East Park Square
Owatonna, MN 55060

EFFECTIVE DATE OF THIS NOTICE

September 23, 2013