



PRINCIPAL HEALTH CARE OF IOWA, INC.
CLASSIC SCHEDULE OF BENEFITS

BENEFIT	MEMBER PAYS
Physician Services Office Visits, Well Child Care, Immunizations, •Newborn Care Annual Gynecological Exam and Pap Test, Specialist Services (Except Maternity) Prenatal and Postnatal Maternity Care . <i>(Physician services, except for prenatal and postnatal maternity care, are limited to one copayment per member per provider per date of service.)</i>	\$5 copayment \$10 copayment \$50 copayment for <u>all</u> office visits
Inpatient Hospital Care Unlimited Hospital Days (Semi-Private), Private Room when Medically Necessary, Medications & Drugs, Nursing Care, Professional Services, X- rays & Laboratory, Intensive/Coronary Care Radiation Therapy •Administration of Blood	\$0 copayment
Outpatient Facility Services X-Ray & Laboratory Ambulatory Surgery	\$0 copayment
Short Term Therapies Physical • Speech • Occupational Respiratory • Cardiac • Rehabilitation <i>(Short-term therapies are limited to 62 consecutive days.)</i>	\$10 copayment
Infertility Services Evaluations, consultations and treatment Including prescription medications	50% coinsurance
Nursing Facility Facility, supplies and equipment authorized in lieu of acute care hospitalization within the service area. limited to 62 consecutive day	\$0 copayment
Home Health Care Authorized in lieu of acute care hospitalization within the service area	\$0 copayment
Hospice Authorized in lieu of acute care hospitalization within the service area	\$0 copayment

Prosthetic Devices and Durable Medical Equipment

Authorized certain prosthetic devices and durable medical equipment 20% coinsurance

Mental Health and Substance Abuse Services

Inpatient facility services up to 30 days per 12 month period 20% coinsurance

Inpatient detoxification \$0 copayment

Outpatient mental health services up to 30 individual or 45 group visits per 12 month period \$15 copayment

Outpatient detoxification services \$10 copayment

Prescription Drugs

\$5 copayment or 25% coinsurance, whichever is greater

Vision Care Services

Annual Eye Exam

From an Optometrist \$0 copayment

From an Ophthalmologist \$10 copayment

Urgent Care Services

At your Primary Care Physician's Office \$5 copayment

At a participating Urgent Care Center (waived if admitted) \$30 copayment

At a nonparticipating Urgent Care Center \$50 copayment or 50% of charges, whichever is less

Emergency Care Services

At a Primary Care Physician's Office \$5 copayment

At a participating Hospital Emergency Room (waived if admitted) \$50 copayment or 50% of charges, whichever is less

At a non-participating Hospital Emergency Room \$50 copayment

(Principal Health Care must be notified within 48 hours of initial treatment emergency.) Or 50% of charges, whichever is less

Ambulance \$0 copayment

Out of Pocket Maximum \$750/individual

(Copayments and coinsurance apply towards the out-of-pocket maximum. The out-of-pocket maximum shall not exceed 200% of annual premium.) \$1,500/family

Exclusions & Limitations

Services not covered include, but are not limited to: services that are not medically necessary; personal or convenience items; over-the-counter drugs and medications not requiring a prescription; custodial care; cosmetic services and surgery; experimental procedures and treatments; and food or food supplements. All services, except in the case of a medical emergency and out-of-area urgent care, must be rendered or authorized by the Primary Care Physician.

The above exclusions and limitations are provided as a brief summary. This is not a complete listing. Please consult your HMO Membership Handbook and Group Membership Agreement to determine the exact terms, conditions and scope of coverage.

Principal Health Care of Iowa, Inc.
Identification Card - Primary

Front

PRINCIPAL HEALTH CARE	
MEMBER NAME R. U. Crazee	NETWORK TYPE Primary Care
MEMBER #: PLAN TYPE:	BENEFITS:
GROUP NAME GROUP #	PCP COPAY \$10
PCP NAME: PCP PHONE #	SPEC COPAY \$25
John Doe, M.D. XXX-XXX-XXXX	ER COPAY \$20
MAILING ADDRESS FOR CLAIMS:	RX COPAY \$ 5 or
Principal Health Care of Iowa, Inc.	25%
XXXX Street Name	
West Des Moines, IA XXXXX	
MEMBER SERVICES PHONE #:	
XXX-XXX-XXXX	

Back

All services must be coordinated through your Primary Care Physician.

Emergency services received at nonparticipating medical facilities must be Reported Principal Health Care of Iowa within 48 hours of their occurrence.

Precertification prior to hospitalization is required to guarantee maximum benefits, XXX-XXX-XXXX.

For Mental Health of Substance Abuse services, prior approval is required and can Be obtained by calling XXX-XXX-XXXX.

Possession of this card does not entitle bearer to coverage unless currently enrolled in Principal Health Care of Iowa.

PRIMARY CARE PLAN

PRINCIPAL HEALTH CARE OF IOWA, INC.SM

CERTIFICATE OF COVERAGE

Copyright Principal Health Care of Iowa, Inc."
May 15, 1992

PRINCIPAL HEALTH CARE OF IOWA, INC
("Health Plan")

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("Certificate") sets forth your rights and obligations as a Member. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Member must pay can be obtained from the Enrolling Group.

Health Plan agrees with the Enrolling Group to provide Coverage for Health Services to Members, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Policy shall take effect on the date specified and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy shall begin at 12:00 a.m. and end at 11:59:59 p.m. Central time.

The Policy is delivered in and governed by the laws of the State of Iowa.

CERTIFICATE

Introduction

You and any of your Enrolled Dependents, for whom the required Premiums have been paid, are entitled to Coverage under the group Policy. The group Policy is referred to in this Certificate as the "Policy."

Coverage under Health Plan is subject to the terms, conditions, exclusions, and limitations of the Policy. As a Certificate, this document describes the provisions of the Policy but it is not the actual Policy. You or your Enrolled Dependents may examine the Policy at the office of the Enrolling Group during regular business hours.

This Certificate replaces and supersedes any Certificate which may have been previously issued to the Subscriber by Health Plan for Health Services rendered after the effective date of the Policy. This Certificate will in turn be superseded by any subsequent Certificates issued to the Subscriber by Health Plan.

How to Use This Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may give you a misleading impression. Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in Section 1 of this Certificate. By using these definitions, you will have a clearer understanding of your Certificate.

From time to time, the Policy may be amended. When that happens, a new Certificate or Amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

Health Services Provided Through Health Plan

In order for Health Services to be Covered under the Policy, you must obtain all Health Services directly from or through your Primary Care Physician Office, with the exception of Medically Necessary Emergency Health Services. So that you will not be required to pay bills for non-Covered services, you must always verify that Health Services are received from your Primary Care Physician Office or by prior approval of your Primary Care Physician Office. See Section 9 of this Certificate for information regarding obtaining Health Services.

Only Medically Necessary Health Services are Covered under the Policy. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for an Injury, Sickness or Mental Illness does not mean that the procedure or treatment is Covered under the Policy.

Members who temporarily reside outside of the Service Area shall be Covered only for Health Services rendered by Health Plan providers, except in the event of an Emergency or upon prior written Health Plan approval.

Contact Health Plan

Throughout this Certificate you will find statements that encourage you to contact Health Plan for further information. Whenever you have a question or concern regarding the Health Services Covered by Health Plan or any required procedure, please contact Health Plan by telephone at (515) 225-1234 or by mail or in person at 4600 Westown Parkway Suite 301, West Des Moines, Iowa 50266-1099.

Identification Card

YOU MUST show your Health Plan identification card every time you request health care services. If you do not show your card, the providers have no way of knowing that you are part of Health Plan and you may receive a bill for health care services.

Possession and use of a Health Plan identification card does not grant entitlement to Coverage. Coverage is subject to verification of eligibility and is also subject to all terms, conditions, limitations and exclusions of the Policy.

SECTION 1

DEFINITIONS

This Section defines, for the purpose of this Certificate, the terms used throughout this Certificate and is not intended to describe Covered or non-Covered services.

"Alternate Facility" -a non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, Emergency Health Services, urgent care services or prescheduled rehabilitative, laboratory or diagnostic services; or inpatient or outpatient Mental Health Services or Chemical Dependency Services.

"Amendment" -any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by Health Plan.

"Ancillary Charge" - a charge in addition to the Copayment which the Member is required to pay to a Participating pharmacy for a Prescription Medication which, through the request of the Member or Participating provider, has not been dispensed in conformance with Maximum Allowable Cost (MAC) List.

"Chemical Dependency Services" - services and supplies Covered under the Policy for the diagnosis and treatment of alcoholism and chemical dependency disorders which are listed in the Diagnostic and Statistical Manual-III-Revised. Specifically, the diagnostic categories are 291.00 through 292.90 inclusive for detoxification and 303.00 through 305.90 inclusive for rehabilitation. The fact that a disorder is listed in the Diagnostic and Statistical Manual-III- Revised does not mean that treatment of the disorder is Covered under the Policy, because other criteria may apply.

"Confinement" and "Confined" - an uninterrupted stay following formal admission to a Hospital" or Participating facility which provides Skilled Nursing Care.

"Copayment" - the charge, in addition to the Premium, which the Member is required to pay for certain Health Services provided under the Policy. A Copayment may be either a defined dollar amount or a percentage of Eligible Expenses. The Member is responsible for the payment of any Copayment directly to the provider of the Health Service at the time of service. The total amount a Member pays in Copayments is subject to a Policy Year maximum limit. See Section 4.2 for information regarding Copayment limits and the recovery of excess Copayments.

"Coverage" or "Covered" - the entitlement by a Member to Health Services provided under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy, including the following conditions: (a) Health Services must be provided when the Policy is in effect;

and (b) Health Services must be provided prior to the date that any of termination conditions (a) through (h) of Section 3.1 occur; and (c) Health Services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Policy.

"Dependent" - a person who is (1) the Subscriber's legal spouse or (2) an unmarried dependent child (including a stepchild, a legally adopted child, a child placed and approved for adoption in the Subscriber's home, or a child for whom legal guardianship has been awarded) of either the Subscriber or the Subscriber's spouse, and (3) whose principal place of residence is with the Subscriber unless Health Plan approves other arrangements. Any unmarried child of the Subscriber whose principal place of residence is not with the Subscriber but who does reside within the Service Area is considered a Dependent if the child meets all other conditions of a Dependent and if the Subscriber is legally required to provide medical care coverage for the child. Enrolled Dependents who temporarily reside outside of the Service Area shall be Covered only for Health Services rendered by Participating providers, except in the event of an Emergency or upon prior written Health Plan approval. The definition of "Dependent" is subject to the following conditions and limitations:

1. The term "Dependent" shall not include any unmarried dependent child of the age or older than the age specified in Article 4.3(a) of the Policy;
2. The term "Dependent" shall include an unmarried dependent child of the ages specified in Article 4.3 (a) of the Policy if evidence satisfactory to Health Plan of the following conditions is furnished upon request:
 - a. the child is not regularly employed on a full-time basis; and
 - b. the child is a Full-time Student; and
 - c. the child is primarily dependent upon the Subscriber for support and maintenance.

The Subscriber agrees to reimburse Health Plan for any Health Services provided to the child at a time when the child did not satisfy these conditions.

"Designated Transplant Facility" - a Hospital, named as such by Health Plan, which has entered into an agreement with or on behalf of Health Plan to render Medically Necessary and medically appropriate Health Services for transplants Covered under the Policy. A Designated Transplant Facility may or may not be located within Health Plan's geographic Service Area.

"Drug Formulary" - a listing of Prescription Medications which are approved for use by Health Plan and which will be dispensed through Participating pharmacies to Members. This list shall be subject to periodic review and modification by Health Plan.

"Eligible Expenses" -Reasonable and Customary Charges for Health Services Covered under the Policy, incurred while the Policy is in effect.

"Eligible Person" - an employee of the Enrolling Group or other person who meets the eligibility requirements specified in both the application and the Policy and who resides and/or is employed within the Service Area.

"Emergency" -a serious medical condition resulting from injury, Sickness or Mental Illness which arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to avoid jeopardy to the life or health of a Member.

"Emergency Health Services" - those Health Services and supplies necessary for the treatment of an Emergency, subject to the conditions and Copayments as described in this Certificate.

"Enrolled Dependent" -a Dependent who is properly enrolled for Coverage under this Policy

"Enrolling Group" -the employer or other defined or otherwise legally constituted group with whom the Policy is made.

"Experimental, Investigational or Unproven Procedures" - medical, surgical, psychiatric, substance abuse or other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by Plan (at the time it makes a determination regarding Coverage in a particular case) to be either: (1) not generally accepted by informed health care professionals in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or (2) not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

"Full-time Student" - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

1. an accredited high school or vocational school; or
2. an accredited college or university; or
3. a licensed technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student at the end of the calendar month during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis. A person continues to be a Full-time Student during periods of vacation established by the institution if the person continues as a Full-time Student immediately following the period of vacation.

"Health Services" - the health care services and supplies Covered under the Policy, except to the extent that such health care services and supplies are limited or excluded under the Policy.

"Home Health Agency" - a program which is engaged in providing home health care services and is authorized pursuant to the law of jurisdiction in which treatment is received.

"Hospital" - an institution, operated pursuant to law, which: (a) is primarily engaged in providing Health Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of, a staff of Physicians; (b) has twenty-four (24) hour nursing services; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association. A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

"Initial Eligibility Period" - the period of time, determined by Health Plan and the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

"Injury" - physiological damage other than Sickness, including all related conditions and recurrent symptoms.

"Maximum Allowable Cost List" - a list of Prescription Medications that will be Covered at a generic product level established by Health Plan. This list is distributed to Participating pharmacies and is subject to periodic review and modification by Health Plan.

"Medically Necessary" - those Health Services which are determined by Health Plan to be necessary to meet the basic health needs of an individual. Determination of Medical Necessity is done on a case-by-case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular Injury, Sickness or Mental Illness does not mean that it is Medically Necessary. In addition, the service must: (1) be consistent with the diagnosis of and prescribed course of treatment for the patient's condition or be generally accepted by the medical community as a preventive Health Service; (2) be required for reasons other than the convenience of the patient or his or her Physician or not be required solely for custodial, comfort or maintenance reasons; (3) be performed in the most cost-efficient type of setting appropriate for the condition, and (4) be rendered at a frequency which is accepted by the medical community as medically appropriate.

"Medicare" - Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Member" -either the Subscriber or an Enrolled Dependent, but applies only while Coverage of such person under the Policy is in effect.

"Mental Health/Chemical Dependency Designee" - the organization, entity or individual which provides or arranges the Mental Health Services and Chemical Dependency Services Covered under the Policy.

"Mental Health Services" - those services and supplies Covered under the Policy for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the Diagnostic Statistical Manual-III-Revised does not mean that treatment for the condition is Covered under the Policy, because other criteria

"Mental Illness" - defined for the purpose of the Policy as those mental health or psychiatric diagnostic categories of the Diagnostic Statistical Manual-III-Revised listed as follows: 290.00-290.43; 293.00-301.90; 302.6 - 302.79; 302.85; 306.51 - 314.01 inclusive and V codes as a Secondary diagnosis unless specifically excluded from Coverage under the Policy

"Non-Participating" -when used to describe a provider of Health Services (such as a Hospital or Physician) means that the provider has not entered into a written agreement with Principal Health Care of Iowa, Inc. to provide Health Services to Members. The participation status of providers will change from time to time.

"Open Enrollment Period" - a period of time subsequent to the Initial Eligibility Period, determined by Health Plan and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

"Participating" - when used to describe a provider of Health Services (such as a Hospital or Physician) means that the provider has entered into a written agreement with Principal Health Care of Iowa, Inc. to provide Health Services to Members. The participation status of providers will change from time to time.

"Physician" -any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

"Policy" - the group Policy, the application of the Enrolling Group, any individual Subscriber applications, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between Health Plan and the Enrolling Group.

"Policy Charge" - the sum of the Premiums for all Subscribers and Enrolled Dependents Covered under the Policy.

"Policy Year" -is calculated from the initial date of Coverage under the Policy and extends for twelve (12) full months beyond.

"Pregnancy" -includes prenatal and postnatal care, childbirth, early termination of Pregnancy, and any complications associated with Pregnancy.

"Premium" - the periodic fee required for each Subscriber and each Enrolled Dependent in accordance with the terms of the Policy.

"Prescription Medication" - a drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill (a legend medication.)

"Prescription Order or Refill" - the authorization for a Prescription Medication issued by a Participating provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

"Primary Care Physician Office" -an individual or group of Participating Physicians which a Member has selected for the provision or coordination of all Health Services Covered under the Policy, whose practice predominately includes pediatrics or family or general practice, and which has entered into a written agreement with Health Plan to provide primary care Health Services to Members.

"Reasonable and Customary Charges" - fees for Health Services which do not exceed the fees that the provider would charge any other payor for the same services.

"Reconstructive Surgery" -surgery which is incidental to an Injury, Sickness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a Physician to have been present at the time of birth.)

"Rider" - any attached description of Health Services Covered under the Policy. Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Health Plan.

"Semi-private Accommodations" -a room with-two (2) or more beds. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available.

"Service Area" -the geographic area served by Health Plan and approved by the appropriate regulatory agency. Contact Health Plan to determine the precise geographic area served by Health Plan. The Service Area may change from time to time.

"Sickness" - physical illness, disease or Pregnancy. The term "Sickness" as used in this Certificate does not include Mental· Illness or chemical dependency.

"Skilled Nursing Care" - Health Services provided to a Member under the direction of the Primary Care Physician Office which are of such complexity that the Health Services must be furnished by a licensed person who is the only type of individual who can safely and effectively deliver the necessary care.

"Subscriber" - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is made by the Enrolling Group.

SECTION 2

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Enrollment. Eligible Persons may enroll themselves and their Dependents in Health Plan during the Initial Eligibility Period or during an Open Enrollment Period by making application on a form provided or approved by Health Plan. In addition, new Eligible Persons and new Dependents may be enrolled in Health Plan as described in Sections 2.3 through 2.5 below. Except as set forth in this section, Eligible Persons and/or Dependents may not enroll in Health Plan without the express written authorization of Health Plan.

Section 2.2 Effective Date of Coverage. Coverage for an Eligible Person and for any of his or her Dependents shall take effect on the date specified in the Policy by Health Plan and the Enrolling Group. If the Eligible Person is not actively at work on the date Coverage would otherwise take effect, Coverage will take effect on the date the Eligible Person returns to active employment. In no event is there Coverage for Health Services rendered or delivered before the effective date of Coverage under this section.

Section 2.3 Coverage for a Newly Eligible Person. Coverage for a newly Eligible Person and any of his or her Dependents shall take effect on the date specified in the Policy by Health Plan and the Enrolling Group if Health Plan receives a properly completed enrollment application within thirty-one (31) days of the date the person first becomes eligible and if Health Plan receives payment for such Coverage, if payment is required.

Section 2.4 Coverage for a New Dependent. Coverage for a new Dependent acquired by a Subscriber by reason of birth, legal adoption or marriage shall take effect on the date of the event if Health Plan is notified by the Subscriber within thirty-one (31) days of the event and if Health Plan receives payment for such Coverage, if payment is required. The Subscriber is responsible for completing a status change form or other appropriate documents and for submitting the documents to Health Plan through the Enrolling Group. If requested by Health Plan, the Subscriber will provide Health Plan with the appropriate documentation of marriage or adoption.

Section 2.5 Involuntary Termination of Employment. Coverage for an Eligible Person and any of his or her Dependents who have lost coverage under another plan due to involuntary termination of employment shall take effect on the date coverage under the other plan is lost if Health Plan receives a properly completed enrollment application and proof (satisfactory to Health Plan) that employment was involuntarily terminated and if Health Plan receives payment for such Coverage, if payment is required.

Section 2.6 Effective Date of Coverage for Confinement. If a Member is Confined on his or her effective date of Coverage, no Coverage is provided for facility charges related to the Confinement. All other Health Services under the Policy will be Covered as of the effective date of Coverage.

SECTION 3

TERMINATION OF COVERAGE

Section 3.1 Conditions for Termination of a Member's Coverage Under the Policy. Subject to continuation and conversion privileges stated in Section 8 of this Certificate. Coverage of the Member under the Policy, including coverage for Health Services rendered after the date of termination for medical conditions arising prior to the date of termination shall automatically terminate on the earliest of the dates specified in (a) through (h) below. Health Plan will notify the Subscriber that Coverage will terminate in writing at least thirty-one (31) days prior to the date of termination, except as specifically stated below.

- (a) The date the entire Policy is terminated, as specified in the group Policy.
- (b) The date specified by Health Plan in written notice to the Subscriber that Coverage under the Policy will terminate because the Member failed to pay a required Copayment for Health Services rendered.
- (c) The date specified by Health Plan in written notice to the Subscriber that all Coverage under the Policy will terminate because the Subscriber knowingly provided Health Plan with false, material information, including, but not limited to, information relating to another person's eligibility for Coverage or status as a Dependent; or false, material information relating to the Subscriber's health status or that of any Dependent Health Plan has the right to rescind Coverage back to the effective date. No prior notice to the Subscriber shall be provided by Health Plan.
- (d) The date specified by Health Plan in written notice to the Subscriber that all Coverage under the Policy will terminate because the Subscriber permitted the use of his or her identification card by any unauthorized person or used another person's card. No prior notice to the Subscriber shall be provided by Health Plan.
- (e) The date a Member's residence and employment are no longer in the Service Area.
The Enrolling Group or Subscriber shall be responsible for notifying Health Plan of a Member's move from the Service Area. Coverage under the Policy will terminate on the date of such move, even if the required notice is not provided to Health Plan. Members who reside outside the Service Area for more than ninety (90) consecutive days will be considered permanent residents elsewhere.
- (f) The date Health Plan receives written notice from the Subscriber or the Enrolling Group instructing Health Plan to terminate Coverage of the Subscriber or any Member or the date requested in such
- (g) The date specified by Health Plan in written notice to the Subscriber that Coverage under the Policy will terminate due to the failure of the Member to follow a prescribed course of treatment.
- (h) The date on which the Member ceases to be eligible as a Subscriber or Enrolled Dependent, unless otherwise specified in the Policy.

In no event will a Member's Coverage be terminated because of his or her health status or

requirements for Health Services.

Under certain circumstances, Members who cease to be eligible for Coverage under the Policy are entitled to continue Coverage under the Policy or to convert to another policy, as described in Section 8 of this Certificate.

Section 3.2 Extension of Coverage for Confinement. If a Member is Confined on the date that Coverage under the Policy would otherwise terminate due to termination condition 3.1(a) (the entire Policy is terminated) and if the Policy is replaced by another group insurance plan, Coverage-related to the Confinement (for facility charges only) shall continue until Confinement ends, until maximum benefits under the Policy have been received or until the end of thirty (30) days, whichever occurs first.

Section 3.3 Payment and Reimbursement Upon Termination. Termination of the Policy shall not affect any request for reimbursement of Eligible Expenses for Health Services rendered prior to the effective date of termination, when such request is furnished as required in Section 4 of this Certificate.

SECTION 4 REIMBURSEMENT

Section 4.1 Reimbursement of Eligible Expenses. Participating providers are responsible for submitting a request for payment of Eligible Expenses directly to Health Plan. In the event a Member is billed by a Participating provider for Eligible Expenses, the Member should contact Health Plan.

When it is appropriate for Health Plan to reimburse a Member, Health Plan shall reimburse Members for Eligible Expenses incurred with non-Participating providers only for EMERGENCY HEALTH SERVICES OR SERVICES AUTHORIZED OR APPROVED BY Health Plan in accordance with the terms of the Policy. Members are responsible for sending a request for reimbursement, on a form provided by or satisfactory to Health Plan, to Health Plan's office within ninety (90) days of the date of service.

The request for reimbursement must be presented on a form provided by Health Plan to which the Member has attached an itemized statement of the Health Services. It is the Member's responsibility to provide the itemized statement in a format and language which can be understood. This is especially important when Emergency Health Services have been rendered in a foreign country.

Failure to provide this information to Health Plan within the time required shall cancel or reduce Coverage unless it was not reasonably possible to have furnished the required information within ninety (90) days. If a Member is legally incapacitated, failure to provide this information to Health Plan within one (1) year of the date of service shall cancel or reduce Coverage. Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Health Services instead of being paid to the Subscriber.

Section 4.2 Reimbursement of Excess Copayments. Health Plan shall reimburse the Subscriber for Copayments paid by any Member in any Policy Year, that exceed the amount stated in Section 10 of this Certificate. In those cases where the Subscriber has enrolled his or her Dependents with Health Plan, Health Plan shall reimburse the Subscriber for Copayments paid by all Members in the family unit in any Policy Year that exceed the amount stated in Section 10 of this Certificate. Any expenses

for non-Covered Health Services are the Member's sole responsibility and will not be reimbursed.

Approved Copayments paid by a Member for Health Services Covered under the Policy, which exceed the maximum Copayment limits shall be reimbursed by Health Plan. For the purpose of reimbursement, Health Plan shall keep track of Copayments paid by the Subscriber and his or her Enrolled Dependents within a Policy Year. Because not all information regarding Copayments is submitted to Health Plan, IT IS THE MEMBER'S RESPONSIBILITY TO FORWARD TO Health Plan INFORMATION REGARDING COPAYMENTS PAID FOR THE FOLLOWING HEALTH SERVICES: PRESCRIPTION DRUGS, PRIMARY CARE PHYSICIAN OFFICE VISITS, DURABLE MEDICAL EQUIPMENT AND MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES.

Such information must include proof satisfactory to Health Plan of the payment of Copayments and must be provided to Health Plan no later than ninety (90) days after the end of the Policy Year.

Section 4.3 Limitation of Action for Reimbursement. No legal proceeding or action may be brought to recover reimbursement prior to the expiration of ninety (90) days after a request for reimbursement has been properly submitted as described above. No such legal proceeding or action may be brought at all unless it is brought within three (3) years of the expiration date.

SECTION 5

COMPLAINT PROCEDURES

Section 5.1 Complaint Resolution. If a Member has a concern or question regarding the provision of Health Services or benefits under the Policy, the Member should contact Health Plan's Customer Service Department at the telephone number or address shown on his or her identification card.

The Customer Service Representative or other authorized person shall attempt to address the concern through informal discussions with the Member.

If the issue is not resolved through informal discussions, the Member may present a written complaint to Health Plan's authorized representative, who shall notify the Member of the resolution of the complaint within thirty-one (31) days following its receipt. If the complaint is not resolved satisfactorily, the Member may submit a written request for a hearing.

Section 5.2 Complaint Hearing. If the Member requests a hearing, a committee shall be appointed by the Chief Executive Officer of Health Plan. The committee shall be empowered to resolve or recommend the resolution of the complaint.

The committee shall advise the complainant of the date and place of a hearing. The hearing shall be held within sixty (60) days following the receipt of the request by Health Plan, at which time testimony, explanation or other information will be received from Subscribers, Enrolled Dependents, Health Plan staff, administrators, providers or other persons deemed by the committee to be necessary for a fair review of the complaint.

The committee shall advise the complainant in writing of its findings within fifteen (15) days of the conclusion of the hearing and of the complainant's right to take the grievance to the Board of Directors of Health Plan for review. Within thirty-one (31) days following receipt of a request for review, the Board of Directors will render its final decision and will advise the complainant of his or her right to take the grievance to the Office of the Commissioner of Insurance.

SECTION 6

GENERAL PROVISIONS

Section 6.1 Entire Policy. The group Policy, including the Certificate of Coverage as Attachment A, the application of the Enrolling Group, any individual Subscriber applications, Amendments and Riders shall constitute the entire Policy of Coverage between parties. All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Policy or be used in defense of a legal action unless it is contained in a written application.

Section 6.2 Limitation of Action. No legal proceeding or action may be brought without first completing, in full, the complaint procedure specified in Section 5 of this Certificate and even then, only if such proceeding or action is brought within three (3) years from the date the cause of action first arose. The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in Sections 4.1 and 4.2 of this Certificate, is subject to the limitation of action provision set forth in that section.

Section 6.3 Time Limit on Certain Defenses. No statement, except a fraudulent statement, made by the Enrolling Group shall be used to void the Policy after it has been in force for a period of two (2) years.

Section 6.4 Amendments and Alterations. Amendments to the Policy shall be effective upon thirty-one (31) days written notice to the Enrolling Group. No change will be made to the Policy unless made by an Amendment or a Rider which is signed by an executive officer of Health Plan. No agent has authority to change the Policy or to waive any of its provisions.

Section 6.5 Relationship Between Parties. The relationships between Health Plan and Participating providers and relationships between Health Plan and Enrolling Groups, are solely contractual relationships between independent contractors. Participating providers and Enrolling Groups are not agents or employees of Health Plan, nor is Health Plan or any employee of Health Plan an agent or employee of Participating providers or Enrolling Groups.

The relationship between a Participating provider and any Member is that of provider and patient. The Participating provider is solely responsible for the services provided by it to any Member. The relationship between any Enrolling Group and any Member is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Member's Coverage through Health Plan) and for the timely payment of the Policy Charge to Health Plan.

Section 6.6 Records. The Member shall furnish Health Plan with all information and proofs which Health Plan may reasonably require with regard to any matters pertaining to the Policy.

By accepting Coverage under the Policy, each Member, including Enrolled Dependents, whether or not such Enrolled Dependents have signed the application of the Subscriber, authorizes and directs any person or institution that has provided services to the Member, to furnish Health Plan or any of Health Plan's designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to the Member. Health Plan agrees that such information and records will be considered confidential. Health Plan and any of Health Plan's

designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment. Health Plan or its providers are permitted to charge a Member reasonable fees to cover costs for completing requested medical abstracts or forms.

Section 6.7 Examination of Members. In the event of a question or dispute concerning Coverage for Health Services, Health Plan may reasonably require that a Member be examined at Health Plan's expense by a Participating Physician acceptable to Health Plan.

Section 6.8 Clerical Error. Clerical error shall not deprive any individual. of Coverage under the Policy or create a right to additional benefits.

Section 6.9 Notice. Written notice given by Health Plan to an authorized representative of the Enrolling Group shall be deemed notice to all affected Subscribers and their Enrolled Dependents in the administration of the Policy, including termination of the Policy.

Section 6.10 Covered Benefits. In no event shall any Member be responsible to pay for benefits received in accordance with the Policy except as otherwise provided in the Policy.

Section 6.11 Workers' Compensation Not Affected. The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by Workers' Compensation Insurance.

Section 6.12 Conformity with Statutes. Any provision of the Policy which, on its effective date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered is hereby amended to conform to the minimum requirements of such statutes and regulations.

Section 6.13 Good Faith. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of Health Plan results in the facilities, personnel or financial resources of Health Plan being unavailable to arrange for the provision of a basic or supplemental health service, Health Plan is required only to make a good faith effort to arrange for the provision of the service, taking into account the impact of the event.

Section 6.14 Plan Administrator. Health Plan is not the Enrolling Group's designated plan administrator for continuation of Coverage under COBRA (Consolidated Omnibus Reconciliation Act), continuation of Coverage under state law, ERISA (Employee Retirement Income Security Act) or any similar legislative act and does not assume any responsibilities of a plan administrator pursuant to federal or state law.

SECTION 7

COORDINATION OF BENEFITS AND SUBROGATION

Section 7.1 Coordination of Benefits Applicability. This coordination of benefits ("COB") provision applies to "This Plan" when a Subscriber or the Subscriber's Enrolled Dependents have health care coverage under more than one "Coverage Plan." The terms "Coverage Plan" and "This Plan" are defined below.

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

determines its benefits first. The above reduction is described in Section 7.4 "Effect on the Benefits of 'This Plan'."

Section 7.2 Definitions. For purposes of Section 7, terms are defined as follows:

"Allowable Expense" - a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more "Coverage Plans" covering the person for whom the claim is made.

The difference between the cost of private accommodations in a Hospital and the cost of semi-private accommodations in a Hospital is not considered an "Allowable Expense" under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the "Coverage Plan."

When a "Coverage Plan" provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an "Allowable Expense" and a benefit paid.

"Claim Determination Period" -a calendar year. However, it does not include any part of a year during which a person has no Coverage under "This Plan," or any part of a year before the date this COB provision or a similar provision takes effect.

"Coverage Plan" -any of these which provides benefits or services for or because of medical or dental care or treatment: (a) group insurance or group-type coverage: whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and coverage other than school accident-type coverage; (b) coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (a) or (b) is a separate "Coverage Plan." Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate "Coverage Plan."

"Primary Plan/Secondary Plan" - the order of benefit determination rules state whether "This Plan" is a "Primary Plan" or "Secondary Plan" as to another "Coverage Plan" covering the person. When "This Plan" is a "Primary Plan," its benefits are determined before those of the other "Coverage Plan" and without considering the other "Coverage Plan's" benefits. When "This Plan" is a "Secondary Plan," its benefits are determined after those of the other "Coverage Plan" and may be reduced because of the other "Coverage Plan's" benefits. When there are more than two "Coverage Plans" covering the person, "This Plan" may be a "Primary Plan" as to one or more other "Coverage Plans" and may be a "Secondary Plan" as to a different "Coverage Plan" or plans.

"This Plan" - the part of the group Policy that provides benefits for health care expenses.

Section 7.3 Order of Benefit Determination Rules. When there is a basis for a claim under "This Plan" and another "Coverage Plan," "This Plan" is a "Secondary Plan" which has its benefits determined after those of the other "Coverage Plan," unless the other "Coverage Plan" has rules coordinating its benefits with those of "This Plan;" and both those rules and "This Plan's" rules, as specified in this Section 7.3, require that "This Plan's" benefits be determined before those of the other "Coverage Plan."

"This Plan" determines its order of benefits using the first of the rules set forth below which applies.

- (a) Non-Dependent/Dependent. The benefits of the "Coverage Plan" which covers the person other than as a dependent are determined before those of the "Coverage Plan" which covers the person as a dependent.
- (b) Dependent Child/Parents Not Separated or Divorced. Except as stated in part (c), when "This Plan" and another "Coverage Plan" cover the same child as a dependent of his or her parents, the benefits of the "Coverage Plan" of the parent whose birthday falls earlier in a year are determined before those of the "Coverage Plan" of the parent whose birthday falls later in that year. However, if both parents have the same birthday, the benefits of the "Coverage Plan" which covered a parent longer are determined first. If the other "Coverage Plan" does not have the rule described in this subsection (b), but instead has a rule based upon the gender of the parent, and if, as a result, the "Coverage Plans" do not agree on the order of benefits, the rule in the other "Coverage Plan" will determine the order of benefits.
- (c) Dependent Child/Parents Separated or Divorced. If two or more "Coverage Plans" cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the "Coverage Plan" of the parent with custody of the child; (2) then, the "Coverage Plan" of the spouse, if any, of the parent with custody of the child; and (3) finally, the "Coverage Plan" of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that "Coverage Plan" are determined first. The "Coverage Plan" of the other parent shall be the "Secondary Plan." This paragraph does not apply with respect to any "Claim Determination Period" or plan year during which any benefits are paid or provided before the entity has that actual knowledge.
- (d) Active/Inactive Employee. The benefits of a "Coverage Plan" which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a "Coverage Plan" which covers that person as a laid off or retired employee (or as that employee's dependent). If the other "Coverage Plan" does not have this rule, and if, as a result, the "Coverage Plans" do not agree on the order of benefits, this part (d) is ignored.
- (e) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the "Coverage Plan" which covered an employee, member or subscriber longer are determined before those of the "Coverage Plan" which covered that person for the shorter term.

Section 7.4 Effect on the Benefits of "This Plan." This Section 7.4 applies when, in accordance with Section 7.3, "This Plan" is a "Secondary Plan" as to one or more other "Coverage Plans." In that event the benefits of "This Plan" may be reduced under this Section 7.4. Such other "Coverage Plan" or plans are referred to as the other "Coverage Plans" below.

The benefits of "This Plan" will be reduced when the sum of the benefits that would be payable for the "Allowable Expense" under "This Plan" in the absence of this COB provision; and the benefits that would be payable for the "Allowable Expenses" under the other "Coverage Plans," in the

absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those "Allowable Expenses" in a "Claim Determination Period." In that case, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other "Coverage Plans" do not total more than those "Allowable Expenses."

When the benefits of "This Plan" are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of "This Plan." Section 7.5 Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. Health Plan has the right to decide which facts it needs. It may obtain needed facts from or give them to any other organization or person. Health Plan need not tell or get the consent of, any person to do this. Each person claiming benefits under "This Plan" must give Health Plan any facts it needs to pay the claim.

Section 7.6 Payments Made. A payment made under another "Coverage Plan" may include an amount which should have been paid under "This Plan." If it does, Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under "This Plan." Health Plan 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.

Section 7.7 Right of Recovery. If the amount of the payment made by Health Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the Policy, it may recover the excess payments.

Section 7.8 Subrogation. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Health Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, of any Member from a third party, including his or her employer, for the reasonable cash value of services provided under the Policy. Health Plan may require assignment of the rights of recovery from the Member, to the extent of the reasonable cash value of services and benefits provided by it plus reasonable costs of collection.

The Member shall cooperate with Health Plan in protecting Health Plan's legal rights under these subrogation provisions and acknowledges that Health Plan's subrogation rights shall be considered as the first priority claim against any third party, to be paid before any other claims which may exist are paid, including claims for general damages by the Member. The Member shall do nothing to prejudice Health Plan's rights under this provision, either before or after the need for services or benefits under the Policy. Health Plan may, at its option, take necessary and appropriate action (to preserve its rights under these subrogation provisions, including the right to bring suit in the name of the Member. Health Plan may collect, at its option, amounts from the proceeds of any settlement or judgment that may be recovered by the Member or his or her legal representative, regardless of whether or not the Member has been fully compensated. Any proceeds of settlement or judgment shall be held in trust by the Member for the benefit of Health Plan under these subrogation provisions and Health Plan shall be entitled to recover reasonable attorney fees from the Member incurred in collecting proceeds held by the Member.

SECTION 8

CONTINUATION OF COVERAGE AND CONVERSION

Section 8.1 Continuation Coverage Under COBRA (Consolidated Omnibus Reconciliation Act). Continuation Coverage under COBRA shall apply only to Enrolling Groups which are subject to the provisions of COBRA. Members should contact the Enrolling Group's plan administrator to determine if he or she is eligible to continue Coverage under COBRA (described in Sections 8.2 through 8.4) or if he or she is eligible to continue Coverage under state law (described in Section 8.5).

Continuation Coverage for Members who selected continuation coverage under a prior plan which was replaced by Health Plan shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 8.4 below, whichever is earlier.

In no event shall Health Plan be obligated to provide continuation Coverage to a Member if the Enrolling Group or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Member in a timely manner of the right to elect continuation Coverage and notifying Health Plan in a timely manner of the Member's election of continuation Coverage.

Health Plan is not the Enrolling Group's designated plan administrator and does not assume any responsibilities of a plan administrator pursuant to federal law.

A Member whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law and as outlined in Sections 8.2 through 8.4 below.

Section 8.2 Qualifying Events for Continuation Coverage. If the Member's Coverage terminated due to one of the following qualifying events, he or she is entitled to continue Coverage. The Member may elect the same Coverage that he or she had at the time of the qualifying event.

- (a) Termination of the Subscriber from employment with the Enrolling Group or reduction of hours, for any reason other than gross misconduct; or
- (b) death of the Subscriber; or
- (c) divorce or legal separation of the Subscriber; or
- (d) loss of eligibility by an Enrolled Dependent who is a child; or
- (e) entitlement of the Subscriber to Medicare benefits; or
- (f) the Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents.

Section 8.3 Notification Requirements and Election Period for Continuation Coverage. The Member must notify the Enrolling Group's designated plan administrator within sixty (60) days of his or her divorce, legal separation or loss of eligibility as an Enrolled Dependent.

Continuation must be elected by the later of sixty (60) days after the Member's qualifying event occurs; or sixty (60) days after the Member receives notice of the continuation right from the Enrolling Group's designated plan administrator.

A Member whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Group's designated plan administrator within forty-five (45) days after electing continuation.

Section 8.4 Terminating Events for Continuation Coverage. Continuation under the Policy will end on the earliest of the following dates:

- (a) Eighteen (18) months from the date continuation began for a Member whose Coverage ended because employment was terminated or hours were reduced, in accordance with qualifying event (a) described in Section 8.2. A Member who is disabled at the time of the qualifying event may extend continuation Coverage to a maximum of twenty-nine (29) months as described below.

A Member who is disabled at the date of qualifying event (a) must provide notice of such disability within sixty (60) days after the determination of the disability, and in no event later than the end of the first eighteen (18) months, in order to extend Coverage beyond eighteen (18) months. If such notice is provided, the Member's Coverage may be extended up to a maximum of twenty-nine (29) months from the date of qualifying event (a) or until the first month that begins more than thirty (30) days after the date of any final determination that the qualified beneficiary is no longer disabled.

- (b) Thirty-six (36) months from the date continuation began for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child or entitlement of the Subscriber to Medicare benefits, in accordance with qualifying events (b), (c), (d) or (e) described in Section 8.2.
- (c) The date Coverage terminates under the Policy for failure to make timely payment of the Premium.
- (d) The date coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition of the Member, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services which are subject to the pre-existing condition limitation or exclusion.
- (e) The date the Member becomes entitled to Medicare, except that this shall not apply in the event the Member's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (f) described in Section 8.2.
- (f) The date the entire Policy ends.
- (g) The date Coverage would otherwise terminate under the Policy.

If a Member is entitled to eighteen (18) months of continuation and a second qualifying event occurs during that time, the Member's Coverage may be extended up to a maximum of thirty-six (36) months from the date Coverage ended because employment was terminated or hours were reduced, in accordance with qualifying event (a) described in Section 8.2. If a Member is entitled to continuation because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (f) described in Section 8.2 and the retired Subscriber dies during the continuation period, the

Enrolled Dependents shall be entitled to continue Coverage for thirty- six (36) months from the date of death. Terminating events (b) through (g) described in this Section 8.4 shall apply during the extended continuation period.

Continuation Coverage for Enrolled Dependents of a Subscriber whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Members should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

Section 8.5 Continuation Coverage Under State Law. A Member who has been continuously Covered under the Policy for a period of at least three (3) full months, who is not entitled to Medicare and who is not eligible for other group health plan coverage, insured or uninsured (unless the Member was covered by the other group health plan immediately prior to the qualifying event) shall be entitled to continuation Coverage under state law if the Member's Coverage was terminated due to one of the following qualifying events:

- (a) death of the Subscriber;
- (b) the Subscriber's termination, temporary layoff, or approved leave of absence from employment;
- (c) a Member's termination of eligibility due to dissolution or annulment of marriage.

The Member must elect continuation Coverage within the later of (a) ten (10) days of the date Coverage would have terminated or (b) ten (10) days of the date the Member is given notice by the Enrolling Group of the right to elect continuation Coverage. Payment of the first Premium must be made to the Enrolling Group within the later of (a) thirty-one (31) days of the date of Coverage would have terminated or (b) twenty-one (21) days after the notice to the Member by the Enrolling Group of the Member's right to continuation. Subsequent Premium must be paid monthly in advance.

Continuation Coverage under state law will end on the earliest of the following dates:

- (a) nine (9) months from the date continuation Coverage began; or
- (b) the date the Member fails to make timely payment of Premium; or
- (c) the date the Member who is a former spouse remarries; or
- (d) the date the Member becomes eligible for Medicare, or for an insured or uninsured group health plan; or
- (e) the date the Policy terminates.

At the end of the continuation period, the Member is entitled to conversion privileges, as described in Section 8.6.

Section 8.6 Conversion. A Member who continues to reside in the Service Area and whose Coverage terminates because:

- (a) the Subscriber is retired or pensioned; or
- (b) because the Member ceases to be eligible as a Subscriber or Enrolled Dependent; or
- (c) because continuation Coverage expires

may make application to Health Plan for coverage under a conversion contract without furnishing evidence of insurability.

Application and payment of the initial Premium must be made within thirty-one (31) days after termination of Coverage under the Policy. A conversion contract shall be issued in accordance with the terms and conditions in effect at the time of application and may be substantially different from Coverage provided under the Policy.

Health Plan may designate a carrier to provide conversion coverage to any Member who no longer resides or is employed within the Service Area and who ceases to be eligible for Coverage because:

- (a) his or her residence and employment are no longer in the Service Area; or
- (b) because the Member ceases to be eligible as a Subscriber or Enrolled Dependent.

Application to convert coverage effective on the date of termination, without furnishing evidence of insurability, must be made to the Health Plan designated carrier within thirty-one (31) days after termination of Coverage under the Policy. A conversion contract may be issued in accordance with the terms and conditions the designated carrier may have in effect at the time of application and may be substantially different from Coverage provided under the Policy.

SECTION 9

PROCEDURES FOR OBTAINING HEALTH SERVICES

Section 9.1 Health Services Rendered by the Primary Care Physician Office. Subject to the terms, conditions, exclusions and limitations of the Policy, a Member is entitled to Coverage for Health Services described in Section 10 of this Certificate if such Health Services are Medically Necessary and are provided by or under the direction of the Member's Primary Care Physician Office.

Coverage for Health Services is subject to payment of the Premium required for Coverage under the Policy and payment by the Member of the Copayment specified for any service.

Section 9.2 Selection of a Primary Care Physician Office. Each Member must select a Primary Care Physician Office which shall be responsible for the coordination of all Health Services rendered to the Member, and for ensuring continuity of care. Selection of a Primary Care Physician Office shall be made for a minor Enrolled Dependent by the Subscriber. Enrolling in Health Plan does not guarantee Health Services by a particular Primary Care Physician Office or Hospital on the list of providers. When a provider on the list no longer has a contract with Health Plan or is not currently accepting new Health Plan Members, you must choose among remaining Participating providers.

If the Member fails to voluntarily select a Primary Care Physician Office within thirty-one (31) days of written notice by Health Plan of the need to do so, Health Plan shall designate the Primary Care Physician Office for that Member.

The Member may change Primary Care Physician Offices at reasonable intervals by completing a form available from Health Plan's administrative office. The Member must submit the form to Health Plan by the twenty-fifth (25th) of the month in order for the change to be effective on the first of the following month.

Section 9.3 Referral Health Services. Health Services Covered under Section 10 of this Certificate must be provided by or through the Member's Primary Care Physician Office. Any Health Services Covered under the Policy that are not provided by the Member's Primary Care Physician Office, except in the case of Medically Necessary Emergency Health Services, the annual gynecological examination benefit described in Section 10.2, and the eye examinations for refractive errors described in Section 10.3 must be provided by the Participating provider authorized in advance by the Member's Primary Care Physician Office. Health Services obtained by the Member without prior authorization from the Member's Primary Care Physician Office are not Covered under the Policy. Health Services recommended by a Participating provider are not Covered until the Member receives prior authorization from the Member's Primary Care Physician Office for such Health Services, even if such services are Medically Necessary.

Additional Health Services recommended by Participating providers after the rendering of the Health Services authorized by the original authorization are Covered only if a new authorization is issued by the Primary Care Physician Office prior to the rendering of the Health Services. All Health Services identified in this Certificate are subject to all of the terms, conditions, exclusions and limitations of the Policy, even if an authorization is obtained by the Member's Primary Care Physician Office.

Section 9.4 Prior Authorization. It is the Member's responsibility to verify that the required authorization has been issued prior to receiving services from a Participating provider other than the Primary Care Physician Office. Should the Member receive care, including hospitalization, from a provider without the required authorization, the Member will be responsible for all costs associated with that care. Failure of the Member's Primary Care Physician Office to issue the necessary prior authorization does not excuse the Member's responsibility to verify the authorization before receiving services from or through Participating providers other than the Primary Care Physician Office. The fact that a Physician orders services or provides prior authorization does not mean that those services will be Covered under the Policy.

Section 9.5 Emergency Health Services by Participating Providers. Health Plan provides Coverage of Eligible Expenses for Medically Necessary Emergency Health Services rendered to a Member, subject to the terms, conditions, exclusions, and limitations of the Policy. Whenever possible, prior to receiving Emergency Health Services, Members should call their Primary Care Physician Office and should seek care from the Participating provider he or she designates. Direction of a Member to Emergency Health Services by the Primary Care Physician Office does not necessarily mean that the Health Services will be Covered under the Policy.

Eligible Expenses for Emergency Health Services are the Reasonable and Customary Charges for the Health Services described in Section 10.8 of this Certificate provided during the course of the Emergency and when Medically Necessary for stabilization and initiation of treatment. The Health Services must be provided by or under the direction of a Physician. Health Services rendered on an Emergency basis are not Covered if, in the opinion of Health Plan, the situation is later determined to be non-Emergency.

Section 9.6 Emergency Health Services by Non-Participating Providers Outside the Service Area. The Member must notify Health Plan within forty-eight (48) hours after Emergency Health Services are initially provided or as soon thereafter as is reasonably possible. Full details of the Emergency Health Services received shall be made available by the Member at the request of Health Plan. Continuation of care after the condition no longer is an Emergency shall require coordination by the Primary Care Physician Office and the prior authorization of Health Plan.

Health Plan will not provide Coverage for Health Services rendered outside the Service Area if the need for care could have been foreseen prior to leaving the Service Area. If the Member is hospitalized, Health Plan may elect to transfer the Member to a Participating Hospital as soon as it is medically appropriate to do so. Services rendered by non-Participating providers or in non-Participating facilities are not Covered if the Member chooses to remain in a non-Participating facility after Health Plan has notified the Member of the intent to transfer the Member to a Participating facility.

Section 9.7 Emergency Health Services by Non-Participating Providers Within the Service Area. In order for Emergency Health Services rendered within the Service Area by non-Participating providers to be Covered under the Policy, one or both of the following criteria must be met: (1) the Emergency must be of such immediate nature that the Member's life would be jeopardized or there would be risk of permanent damage to the Member's health if taken to a facility where the services of a Participating Physician would be available. or (2) the Emergency Health Services must be provided under circumstances in which the Member is unable, due to unconsciousness or the inability to be rational, to request treatment at a location where the services of a Participating Physician would be available.

Section 9.8 Second Opinion Policy. Coverage of certain Health Services may require that the Member consult a second Participating Physician prior to the scheduling of the Health Service. The Primary Care Physician Office would notify the Member that a particular Health Service is subject to a second opinion policy and would inform the Member of the required procedure for obtaining a second opinion.

Section 9.9 Conditions for Coverage of Mental Health/Chemical Dependency Services. The Mental Health Services and Chemical Dependency Services specified in Sections 10.12 through 10.14 are Covered only when provided by or authorized in advance by the Mental Health/Chemical Dependency Designee. The Primary Care Physician Office shall refer Members to the Mental Health/Chemical Dependency Designee. Referrals to any Participating provider for Mental Health/Chemical Dependency Services shall in all cases be at the discretion of the Mental Health/Chemical Dependency Designee.

SECTION 10

SCHEDULE OF BENEFITS

The total Copayments paid by any Subscriber in any Policy Year shall not exceed the lesser of \$750 or 200% of Premium; the total Copayment paid by all Members in a family unit, if the Subscriber has enrolled his or her Dependents shall not exceed the lesser of \$1500 or 200% of Premium.

Section 10.1 Medical Services in a Primary Care Physician's Office. Services and supplies ordered and provided by or under the direction of the Member's Primary Care Physician Office in the Physician's office, including the preventive medical care such as well-baby care, routine physical examinations, voluntary family planning, and immunizations.

COPAYMENT: \$5 per Member per visit except for Copayments required for specific services and supplies set forth below. No Copayment applies for prenatal services.

Section 10.2 Medical Services in a Referral Physician's Office. Services and supplies provided by a Physician including nutritional counseling, upon referral or the Primary Care Physician Office.

COPAYMENT: \$10 per Member per visit except for Copayments required for specific services and supplies set forth below. No Copayment applies for prenatal services.

Services and supplies provided by a Participating Physician for an annual gynecological examination. Coverage is limited to one (1) visit per Member per twelve (12) month period and does not require referral by the Member's Primary Care Physician Office, but does require prior written authorization from Health Plan.

COPAYMENT: \$10 per Member per visit, except for Copayments required for specific services and supplies set forth below.

Section 10.3 Eye Examinations For Refractive Errors. Eye examinations for refractive errors provided by a Participating provider in the provider's office. Coverage is limited to one (1) examination to detect vision impairment per Member per twelve (12) month period and does not require referral by the Member's Primary Care Physician Office but does require prior written authorization from Health Plan.

COPAYMENT: \$0 per visit for services provided by an optometrist; \$10 per visit for services provided by an ophthalmologist.

Section 10.4 Surgical and Medical Services. Surgical services and other medical care ordered by and provided by or under the direction of a Primary Care Physician Office while the Member is Confined in a Participating Hospital, a Participating Alternate Facility or a Participating facility which provides Skilled Nursing Care.

COPAYMENT: 0% of Eligible Expenses

Section 10.5 Infertility Services. Services and supplies for testing and diagnosis of infertility when ordered by and provided by or under the direction of a Primary Care Physician Office in the Physician's office or provided at a Participating Hospital or Participating Alternate Facility on an inpatient or outpatient basis. No Coverage is provided for the treatment of infertility (including prescription medications, in vitro fertilization, gamete intrafallopian transfer (GIFT), or gamete intrafallopian tube transfer (ZIFT) procedures 1

COPAYMENT: 50% of Eligible Expenses

Section 10.6 Inpatient Hospital and Related Services. Medically Necessary Confinement including room and board, and services and supplies provided during Confinement in a Participating Hospital on a Semi-private Accommodations basis when ordered, provided or arranged under the direction of a Primary Care Physician Office. Certain Health Services rendered during a Member's Confinement are subject to separate benefit restrictions as described elsewhere in this Certificate.

COPAYMENT: \$0 per day

Section 10.7 Inpatient Hospital and Related Services for Transplants. Confinement, including room, board, related services and supplies provided in a Designated Transplant Facility when ordered, provided or arranged under the direction of a Primary Care Physician Office and authorized in advance by Health Plan. Coverage is provided for kidney, corneal, heart and liver organ transplants and for bone marrow transplants when performed in accordance with Health Plan's guidelines on transplantation Health Services when such transplants are Medically Necessary and medically appropriate. Requests for transplants will be considered on an individual basis by Health Plan's Medical Director and/or the Utilization Review Committee and may not be Covered if the transplant is not medically appropriate. Transplants are not Covered unless rendered in a Designated Transplant Facility, in accordance with Health Plan's guidelines for transplantation Health Services, and are subject to exclusion (i) of Section 11. Contact Health Plan for information regarding Health Plan's guidelines on transplantation Health Services.

COPAYMENT: Same as Section 10.6

Section 10.8 Emergency Outpatient Services and Supplies. Services and supplies for stabilization or initiation of treatment of Emergency conditions provided on an outpatient basis as either a Hospital or an Alternate Facility.

COPAYMENT: Either:

- a. the lesser of 50% of Eligible Expenses or \$50 per visit for Emergency Health Services rendered by a Participating Hospital, except the Copayments specified in Section 10.6 and Section 10.16 shall apply when Confinement occurs for the same condition within twenty-four (24) hours: OR
- b. the lesser of 50% of Eligible Expenses or \$50 per visit for Emergency Health Services rendered by an Alternate Facility, except the Copayments specified in Section 10.6 and Section 10.16 shall apply when Confinement occurs for the same condition within twenty-four (24) hours: OR
- c. the lesser or 50% of Eligible Expenses or \$50 per visit for Emergency Health Services rendered by a non-Participating Hospital: OR

- d. the lesser of 50% or Eligible Expenses or \$50 per visit for Emergency Health Services rendered by a non-Participating Alternate Facility.

Outpatient Prescription Medications provided by a Hospital, Alternate Facility or pharmacy in conjunction or pharmacy in conjunction with Emergency Health Services for the same condition, not to exceed a consecutive three (3) day supply.

COPAYMENT: The greater of \$5 or 25% of Eligible Expenses per Prescription Order or Refill.

Section 10.9 Outpatient Surgery. Services and supplies for prescheduled outpatient surgery provided under the direction of the Primary Care Physician Office at a Participating Hospital or Participating Alternate Facility.

COPAYMENT: 0% of Eligible Expenses

Section 10.10 Outpatient Diagnostic and Therapeutic Services. Services and supplies for prescheduled laboratory and radiologic diagnostic tests and therapeutic treatments provided under the direction of the Primary Care Physician Office at a Participating Hospital or Participating Alternate Facility.

COPAYMENT: 0% of Eligible Expenses

Section 10.11 Maternity Services. Maternity-related medical, Hospital and other Covered Health Services shall be treated as any other Sickness and/or Injury.

COPAYMENT: Same as Sections 10.4 and 10.6 for inpatient services. A \$50 Copayment shall apply for obstetrical services provided during delivery in lieu of any am prenatal office visit Copayment.

Section 10.12 Outpatient Mental Health/Chemical Dependency Services. Coverage to a maximum of thirty (30) visits per twelve month period. when provided through a mental health or chemical dependency evaluations and referral services. short-term individual and/or group outpatient therapeutic services and crisis intervention. Referrals to a Participating provider shall in all cases be at the sole discretion of Health Plan or us Mental Health/Chemical Dependency Designee. (for the purpose of calculating the maximum number of outpatient visits. two individual visits equals three group visits.)

COPAYMENT: \$15 per visit. THE MEMBER IS RESPONSIBLE FOR PAYING THE FULL REASONABLE AND CUSTOMARY CHARGE FOR EACH APPOINTMENT NOT KEPT OR CANCELED LESS THAN TWENTY-FOUR (24) HOURS PRIOR TO THE TIME OF THE SCHEDULED VISIT.

Section 10.13 Inpatient Mental Health/Chemical Dependency Services. Coverage for Semi-private Accommodations. to a maximum of thirty (30) days per twelve month period for Mental Health and/or Chemical Dependency Services when authorized in advance by Mental Health/Chemical Dependency Designee. (Unused inpatient days can be exchanged for additional outpatient visits. For the purpose of calculating the exchange, one inpatient day equals two outpatient visits.) The maximum number of unused inpatient days which can be exchanged is five (5).

COPAYMENT: 20% of Eligible Expenses

Section 10.14 Detoxification Services. Coverage for inpatient or outpatient (whichever is Medically Necessary) Chemical Dependency Services limited to physical detoxification. Detoxification services must be provided by or authorized in advance by the Primary Care Physician Office. (Inpatient detoxification services must be received on a Semi-private Accommodations basis.)

COPAYMENT: \$10 per visit for outpatient services; 0% of Eligible Expenses per day for inpatient services.

Section 10.15 Home Health Agency Services. Part-time, intermittent Health Services of a Participating Home Health Agency, by or under the supervision of a registered nurse, in a Member's home, required for care and treatment which otherwise would require Confinement in a Participating Hospital or Participating facility which provides Skilled Nursing Care. Home Health Agency services must be provided under the direction of the Primary Care Physician Office and approved in writing in advance by Health Plan.

COPAYMENT: 0% of Eligible Expenses

Section 10.16 Skilled Nursing Care. Up to sixty-two (62) days per Policy Year of Medically Necessary Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of the Primary Care Physician Office in a Participating facility which provides Skilled Nursing Care. Health Services are Covered only for the care and treatment of an Injury or Sickness which otherwise would require Confinement in a Participating Hospital. when approved in writing in advance by Health Plan. Certain Health Services rendered during a Member's Confinement are subject to separate benefit restrictions described elsewhere in this Certificate.

COPAYMENT: 0% of Eligible Expenses

Section 10.17 Ambulance Services. Emergency- ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered.

COPAYMENT: 0% of Eligible Expenses

Non-Emergency surface ambulance transportation when recommended by the Primary Care Physician Office and approved in writing in advance by Health Plan.

COPAYMENT: 0% of Eligible Expenses

Section 10.18 Accident-related Dental Services. Services performed by a Doctor of Dental Surgery, "D.D.S.," for treatment of any sound natural teeth made necessary as a result of Injury (except Injury resulting from biting or chewing) occurring while Coverage under the Policy is in force. No Coverage is provided unless the dentist certifies to Health Plan that teeth were sound natural teeth which were injured as a result of an accident, the services are provided and completed within six (6) months of the Injury, and the services are approved in advance by Health Plan. No Coverage is provided for dental implants or prostheses; procedures associated with the fitting of dentures or dental implants; orthodontia or tooth extraction. (Sound natural teeth are free of active or chronic clinical decay, have at least fifty percent (50%) bony support. and are functional in the arch.)

COPAYMENT: 20% of Eligible Expenses

Section 10.19 Prosthetic Devices and Durable Medical Equipment. Coverage for prosthetic devices and durable medical equipment when approved in writing by Health Plan, obtained from a vendor or provider selected by Health Plan and if ordered by or provided by or under the direction of the Primary Care Physician Office for use outside a Participating Hospital or Participating facility which provides Skilled Nursing Care. Coverage is provided for prosthetics and durable medical equipment which meet the minimum specifications which are Medically Necessary. No Coverage is provided for repair, replacement or duplicates nor is Coverage provided for Health Services related to the repair or replacement except when necessitated due to a change in the Member's medical condition. Not all prosthetics, orthotic appliances and durable medical equipment are Covered under the Policy, even if ordered by a Physician and/or Medically Necessary.

- (a) Initial purchase of artificial limbs, artificial eyes, and other Medically Necessary prosthetic devices or orthotic appliances made necessary as a result of Injury or Sickness occurring while Coverage under the Policy is in force (Prosthetic devices and body functioning or replace a limb or body part. and Orthotic appliances correct a defect or body form or function.)

COPAYMENT: 20% of Eligible Expenses

- (b) (Rental or purchase, at the discretion of Health Plan, of durable medical equipment. Including, but not limited to, the following: Braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded); oxygen and the rental of equipment for the administration of oxygen; standard wheelchairs; standard Hospital-type beds; mechanical equipment necessary for the treatment of chronic or acute respiratory failure, except that air-conditioners, humidifiers, dehumidifiers, and other personal comfort items are excluded. (Durable medical equipment means medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a Sickness or Injury, and is appropriate for use in the home.) Certain medical supplies such as colostomy bags, syringes and diabetic test strips are included in the durable medical equipment benefit.

COPAYMENT: 20% of Eligible Expenses; 0% of Eligible Expenses if provided in lieu of Hospital Confinement

Section 10.20 Rehabilitation Services. Short-term inpatient or outpatient (whichever is Medically Necessary) rehabilitation services which are expected to result in significant improvement in the Member's condition within two (2) months of start of treatment limited to physical therapy, occupational therapy, and speech therapy. Rehabilitation services are limited to services which, in the judgment of the Primary Care Physician Office and Health Plan, are Medically Necessary and will result in significant improvement of a Member's condition through short-term therapy. Rehabilitation services are limited to sixty-two (62) consecutive days per Policy Year. Rehabilitation services must be provided under the direction of the Primary Care Physician Office, approved in writing in advance by Health Plan and performed in a Participating Hospital or Participating facility which provides Skilled Nursing Care or through a Participating Home Health Agency or other Participating provider. -

COPAYMENT: \$10 per visit for outpatient rehabilitation services: same as Section 10.6 for inpatient rehabilitation services, when an inpatient Copayment applies.

Section 10.21 Outpatient Prescription Medications. Outpatient Prescription Medications as contained in the Drug Formulary, which have been prescribed by a Participating provider and obtained through a Participating pharmacy. Outpatient Prescription Medications shall, in all cases, be dispensed in accordance with the Drug Formulary and only those Prescription Medications included in the Drug Formulary, as amended from time to time, are Covered, unless authorized in advance by Health Plan.

COPAYMENT: The greater of \$5 or 25% of Eligible Expenses per Prescription Order or Refill. For a single Copayment, a Member may obtain one or the following:

- Up to a consecutive thirty (30) day supply of a Prescription Medication, unless limited by the drug manufacturer's packaging;
- Up to four (4) ounces of a cream or ointment;
- A one (1) cycle supply of oral contraceptives;
- One (1) vial of insulin (OTC);
- Up to a three (3) month supply of nicotine patches. The Member will be reimbursed for Eligible Expenses, minus the Copayment. Eligibility for reimbursement is subject to specific guidelines. Contact Health Plan for information regarding the guidelines for reimbursement of nicotine replacement therapy.

A Member shall pay to a Participating pharmacy:

- The added cost (Ancillary Charge) of any Prescription Medication which, at the request of the Member or Participating provider, is not dispensed in accordance with the Maximum Allowable Cost List, or
- 100% of the cost of a Prescription Order or Refill when the Member fails to show his or her identification card, or
- 100% of the Copayment or 100% of the total of the Copayment and Ancillary Charge, whichever is applicable, or
- 100% of a medication not Covered in the Drug Formulary, or
- The lesser of the Copayment or the Participating pharmacy's usual and customary charge which would be charged to a non-Member.

Section 10.22 Implants and Related Health Services. Coverage for implant devices and related implantation Health Services including cochlear implants, penile implants, implants for the purpose of contraception and implants for the delivery of prescription medication when provided in accordance with Health Plan's guidelines and approved in writing in advance by Health Plan. Implants for the purpose of contraception are limited to one (1) every four (4) years. Contact Health Plan for information regarding Health Plan's guidelines on implantation Health Services.

COPAYMENT: 40% of Eligible Expenses

Section 10.23 Growth Hormone Therapy. Growth hormone therapy provided by or under the direction of the Primary Care Physician Office. Growth hormone therapy is Covered only when Medically Necessary and must be authorized in advance in writing by Health Plan. Authorization for growth hormone therapy is limited to a single month's supply at one time.

COPAYMENT: The greater of 25% of Eligible Expenses or \$5 per one month's supply.

Section 10.24 Temporomandibular Joint Syndrome Services. Medically Necessary surgical and non-surgical procedures performed by a Participating Physician or a dentist as designated by Health Plan for the treatment of temporomandibular joint syndrome when provided by or under the direction of the Member's Primary Care Physician Office. Services not provided by or under the direction of the Member's Primary Care Physician Office are not Covered. Any Covered appliance required for the treatment of temporomandibular joint syndrome will be subject to the Copayment stated in Section 10.19.

COPAYMENT: 20% of Eligible Expenses

Section 10.25 Glasses/Contact Lenses Following Cataract Surgery. Coverage for (1) the first pair of glasses or (2) the first pair of contact lenses following cataract surgery, provided by or under the direction of the Primary Care Physician Office. No Coverage is provided for replacement glasses or contact lenses

COPAYMENT: 20% of Eligible Expenses

Section 10.26 Osteopathic Manipulative Therapy (OMT). Osteopathic manipulative therapy (OMT), when provided upon referral of the Primary Care Physician Office. .

COPAYMENT: \$10 per Member per visit.

SECTION 11

GENERAL EXCLUSIONS

Section 11.1 Exclusions. The following are not Covered:

- (a) Dental services provided by a Doctor of Dental Surgery, "D.D.S.." or by a Physician licensed to perform such dental services (including such for overbite or underbite, maxillary and mandibular osteotomies and non-Medically Necessary temporomandibular joint syndrome) or dental x-rays, supplies and appliances (including occlusal splints) and all associated expenses arising out of such dental services including hospitalizations, except as provided in Section 10.18, Section 10.18, Section 10.24 or through signed Rider to Policy.
- (b) Custodial care, domiciliary care, private duty nursing, respite care or rest cures, (Custodial care means non-health related services, such as assistance in activities of daily living o health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing or which do not require continued administration by trained medical personnel.)
- (c) Personal comfort and convenience items or services such as television, telephone, barber or beauty services, guest services and similar incidental services and supplies.
- (d) Health Services and associated expenses for cosmetic procedures, including, but not limited to, pharmacological regimens, nutrition procedures or treatments, plastic surgery, and non-Medically Necessary Reconstructive Surgery. (Cosmetic procedures are those procedures which improve physical appearance, but which do not correct or materially improve a physiological function and are not Medically Necessary).
- (e) Health Services and associated expenses for procedures intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, and Health Services of a similar nature, unless Medically Necessary. Health Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.
- (f) Health Services and associated expenses for Experimental, Investigational or Unproven Procedures, treatments, devices and pharmacological regimens. The fact that an Experimental, Investigational or Unproven Procedure, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- (g) Health Services and associated expenses for megavitamin therapy: psychosurgery: radial keratotomy and other refractive eye surgery: nutritional-based therapy for alcoholism or other chemical dependency: salabrasion chemosurgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne: acupuncture: hypnotism: pain therapy: services and supplies for smoking cessation programs and treatment of nicotine addiction. except as specifically stated in Section 10.21, as amended effective April 1, 1992, and in accordance with Health Plan's guidelines for

nicotine replacement therapy.

- (h) Health Services and associated expenses for removal of an organ from a Member purposes or transplantation into another person: Health Services and associated expenses for transplants involving mechanical or animal organs.
 - (i) Health Services and associated expenses for organ or tissue transplants are excluded, except those specifically stated in Section 10.7 and in Health Plan's guidelines for transplantation Health Services.
 - (j) Health Services and associated expenses for the treatment of infertility including in vitro fertilization, gamete intrafallopian transfer (GIFT) and gamete intrafallopian tube transfer (ZIFT) procedures: embryo transport: surrogate parenting: donor semen and related costs including collection and preparation: and non-Medically Necessary amniocentesis.
 - (k) Health Services and associated expenses for sex transformation operations and for reversal of voluntary sterilizations.
 - (l) Health Services and associated expenses for implants are excluded, except as specifically stated in Section 10.22 and in Health Plan's guidelines for implantation Health Services.
 - (m) Prosthetic and orthotic devices, durable medical equipment and appliances, and personal comfort items, including air-conditioners, even though prescribed by a Physician, except as provided under Section 10.19 of the Policy.
 - (n) Hearing aids, eye glasses, contact lenses and the fitting thereof, except as described in Section 10.25
 - (o) Travel or transportation expenses, except ambulance service as specifically described in this Certificate, even though prescribed by a Participating Physician.
 - (p) Health Services for treatment of military service-related disabilities when the Member is legally entitled to other coverage and for which facilities are reasonably available to the Member.
 - (q) Mental Health and/or Chemical Dependency Services, when such services extend beyond the period necessary for short-term evaluation. Diagnosis, treatment or crisis intervention and when the treatment of Mental Illnesses will not substantially improve the disorder beyond the current level of functioning.
 - (r) Services for the treatment of disorders, disabilities or addictions described in the following diagnostic categories of the Diagnostic and Statistical Manual-III-Revised:

Paraphilias	302.2-302.5; 302.81 - 302.84: and 302.9
Nicotine Dependence Caffeine	305.1
Intoxication Conduct Disorders	305.90
Learning Disabilities	312.31 -312.90
Mental Retardation	315.00- 315.80
Autistic Disorder	317.00 - 319.00
	299.00 - 299.80
- All V-Codes (e.g., marital problems, academic problems, etc.) as a primary diagnosis
- (s) Treatment for Mental Illness or chemical dependency when required by court order when such order is made without the knowledge or the Mental Health/Chemical Dependency Designee or is inconsistent with the Mental Health/Chemical Dependency Designee's assessment and recommendation for treatment: treatment of sexual offenders and perpetrators of physical or sexual violence: provision of structured sex therapy **programs**.

- (t) Inpatient Mental Health Services or Health Services provided by a chemical dependency treatment or rehabilitation program, except as specified in Section 10 or unless Covered through a signed Rider to the Policy.
- (u) Prescription medications for outpatient treatment, except as provided in Section 10.21 of this Certificate and as amended effective April 1, 1992; appetite suppressants; compounded Prescription Medications with ingredients not requiring a Prescription Order or Refill; Experimental Investigational or Unproven medications; medications for cosmetic purposes only; medications for smoking cessation, except as specifically provided in Health Plan's guidelines for nicotine replacement therapy; medications available over-the-counter (OTC) that do not require a Prescription Order or Refill by federal or state law and any medication that is equivalent to an over-the-counter (OTC) medication; medications used for experimental indications and/or dosage regimens determined by Health Plan to be experimental; medications with no approved FDA indications; prescriptions from providers not contracted with Health Plan, except in the case of an Emergency; dental prescriptions; replacement prescriptions resulting from loss or theft; all enteral feeding and other over-the-counter nutritional and electrolyte supplements.
- (v) Physical, psychiatric or psychological examinations or testing or vaccinations, immunizations or treatments, when such services are for purposes of obtaining, maintaining or otherwise relating to career education, employment or insurance, marriage or adoption or relating to judicial or administrative procedures or orders or which are conducted for purposes of medical research or to obtain or maintain a license or any type.
- (w) Devices used specifically as safety items or to affect performance primarily in sports-related activities: all expenses related to physical conditioning programs such as athletic training, Body-building, exercise, fitness, flexibility, and diversion or general motivation.
- (x) Health Services not provided by or under the direction of the Primary Care Physician Office, except in Emergency situations (described in Sections 9.6 through 9.8, and Section 10.8); referral services authorized in writing in advance to the Health Plan (described in Section 9.4 and Section 9.5); the annual gynecological examination (described in Section 10.2) and the annual vision examination (described in Section 10.3.)
- (y) Health Services and associated expenses for outpatient Hospital, Alternative Facility, and Hospital Emergency room services obtained during normal Physician office hours, unless necessary because of an Emergency or as specified in Section 10 or when authorized in advance in writing by the Mental Health/Chemical Dependency Designee or Health Plan
- (z) Health Services not provided by or under the direction of a single Primary Care Physician Office and a single network of Participating providers as required in Section 9.3 of this Certificate, except in Emergency situations or when Medically Necessary Health Services are not available at the single Participating Hospital in which case prior Health Plan approval is required.
- (aa) Health Services otherwise Covered under the Policy related to a specific condition when a Member has refused to comply with or has terminated the scheduled service or treatment against the advice of a Participating Physician or the Mental Health/Chemical Dependency Designee.
- (bb) Health Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Health Services for medical conditions arising prior to the date individual Coverage under the Policy terminates.
- (cc) Health Services which are not Medically Necessary and which are related to

complications arising from treatments or services otherwise excluded under the Policy.

- (dd) Health Services which may be Medically Necessary but which are not medically appropriate, as determined by Health Plan, for the treatment of a particular condition.
- (ee) Chiropractic services, treatment or care except as described in Section 10.2

Amendment B

Amendment to the Group Contract

State of Iowa Group Enrollment/Eligibility Restrictions (Active Employees)

Eligible Employees

Eligible employees shall be those employees of the State of Iowa who work at least 20 hours per week, who are employed in either a permanent position or in positions covered by collective bargaining agreements, and who enroll as specified below in a health plan option included in the State or Iowa group health insurance program.

New Employees

New employees may enroll in single or family coverage without underwriting within thirty (30) calendar days of their date of employment or during the first enrollment and change period following their date of employment. State PROMISE Program hires (as established by Executive Order Number 27, March 3, 1987) and their dependents may enroll without underwriting if they enroll within thirty (30) calendar days of expiration of their Medicaid benefits. Employees and dependents not enrolled during these periods will be subject to underwriting in all non-federally qualified HMOs, except for dependent enrollment during the first enrollment and change period following date of employment or at the time of an event. Federally qualified HMOs agree to also add dependents without underwriting at the time of an event and during the first enrollment and change period following date of employment.

Annual Enrollment and Change Period

Beginning in June of each year, there will be a thirty (30) calendar day annual enrollment and change period when employees may change their health plan elections without underwriting between such plan elections as offered in the State of Iowa group health insurance program. During this period employees may not initially enroll themselves nor enroll additional dependents in the State of Iowa group health insurance program except as specified elsewhere in this amendment.

Changes During a Plan Year

Changes from family to single coverage may be made at any time during the year and will not require medical underwriting.

Under certain circumstances, employees enrolled in a State health program may change from single to family coverage, or add dependents to an existing family contract during the year without medical underwriting provided that timely application is made and that only dependents directly affected by the event are added to coverage

A change may be made if a new application is submitted within thirty (30) calendar days of any of the following events:

Marriage

Death of spouse or dependent

Adoption of a child, addition of step children or foster children to the family

Employee or spouse reaches age 65

Spouse involuntarily loses coverage through another Employer group due to layoff, plant closing, company closing

Employee, spouse or dependent become eligible for Medicare

Divorce, annulment, legal separation, or dissolution of marriage

Dependent no longer eligible (age 19 and over and no longer a full time student or dependent marries)

Birth of a child:

An enrollment form must be completed by the subscriber within 30 days of the birth, if a single contract is in effect at the time of the birth of the biological child, the employee must submit a family application form to the Personnel Assistant within 30 days of the date of this birth. The effective date of the family contract will be the first day of the month in which the biological child was born. The employee's share of the family premium begins with this effective date. If the single contract holder does not submit the application for family coverage within 30 days of the birth of the biological child, the child's application will require medical underwriting and benefit payment will not be made retroactive to the date of birth.

Special Enrollment Opportunities

Any and all of the above eligibility requirements may be waived upon mutual written agreement signed by the parties to this contract.

Louis B. Garcia
Executive Director

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Amendment C

Amendment To The Group Contract

State of Iowa Group Complaint/Appeal Procedure

State of Iowa group subscribers may file written appeals with the HMO regarding any denial of services or benefits. The HMO will provide a final written response to the subscriber not later than sixty (60) calendar days following receipt of the appeal. If upon final HMO response to the appeal the State of Iowa group subscriber is not satisfied with the HMO's decision, such State of Iowa group subscriber may appeal the decision to the Iowa Department of Personnel.

Louis B. Garcia
Executive Director

Amendment G

Amendment to Group Contract

Any employee and/or former employee defined as eligible by the State of Iowa, whether "actively at work" or not is accepted by the health plan as an approved Member on August 1 of the year the Member chooses the health plan during an approved enrollment and change period.

After the effective date of the Member's coverage the new health plan will not pay for Covered Services provided to a Member who is an inpatient and/or confined in a Hospital or a Nursing facility on the date the coverage would otherwise be effective. Payment for such Covered Services will be made by the Member's previous health plan for the greater of the following periods: (A) a period equal to the Member's remaining days of coverage under the Agreement; or (B) a period ending on the date the Member is discharged from the Hospital or Nursing Facility, not to exceed sixty (60) days from the date the coverage is terminated. All inpatient Hospital, Physician, and any other related charges for the Member terminating from one health plan and joining another, are to be paid by the health plan from which the Member is terminating until discharge, or for a period not to exceed sixty (60) days from the date coverage is terminated.

Immediately upon Hospital or Nursing Facility discharge, or a period beginning sixty (60) days and one minute from the date coverage is terminated from the previous health plan, the Member's newly chosen health plan will be liable, and will pay, for all contractually covered charges for the Member choosing that health plan, including, inpatient Hospital and Physician expenses. All coverage incorporates and assumes contractual copayments, deductibles, coinsurance, exclusions, out-of-pocket annual maximums, and other accepted contractual limitations.

This language supersedes any other contractual language regarding the Member's effective date, benefits available eligibility and/or payment for inpatient Hospital Nursing Facility. Physician, and/or other inpatient charges for State of Iowa Group Members.

Louis B. Garcia
Executive Director

Amendment H

Amendment to Group Contract

All eligible persons requesting to continue coverage through COBRA, Retiree or Long Term Disability programs with the State of Iowa Group will be billed directly by the insurance carrier.

The state agrees to collect from the enrollee the first month's premium payment and all necessary forms for enrollment.

The carrier will be notified of the request for continuation coverage and thereafter will directly bill the enrolled for premium payment.

The following payment options may be made available:

- Monthly automatic payment plan
- Monthly direct bill
- Quarterly direct bill

Louis B. Garcia
Executive Director

Amendment I
State of Iowa Employees

Amendment to Group Contract

Eligible Employees

Eligible employees shall be those employees and/or dependents who live or work in Health Plan's Service Area defined as Boone, Clarke, Dallas, Guthrie, Jasper, Madison, Marion, Marshall, Polk, Story, and Warren Counties.

Louis B. Garcia
Executive Director

AMENDMENT TO EXTEND COVERAGE HANDICAPPED DEPENDENTS

The Policy is amended to extend Coverage for handicapped Dependents. The definition of "Dependent" in Section 1 "Definitions" is replaced with the following definition:

"Dependent" -a person who is (1) the Subscriber's legal spouse or (2) an unmarried dependent child (including a stepchild, a legally adopted child, a child placed and approved for adoption in the Subscriber's home, or a child for whom legal guardianship has been awarded) of either the Subscriber or the Subscriber's spouse and (3) whose principal place of residence is with the Subscriber unless Health Plan approves other arrangements. Any unmarried child of the Subscriber whose principal place of residence is not with the Subscriber but who does reside within the Service Area is considered a Dependent if the child meets all other conditions of a Dependent and if the Subscriber is legally required to provide medical care coverage for the child. Enrolled Dependents who temporarily reside outside of the Service Area shall be Covered only for Health Services rendered by Participating providers except in the event of an Emergency or upon prior written Health Plan approval. The definition of "Dependent" is subject to the following conditions and limitations:

1. The term "Dependent" shall not include any unmarried dependent child of the age or older than the age specified in Article 4.3(a) of the Policy;
2. The term "Dependent" shall include an unmarried dependent child of the ages specified in Article 4.3 (a) of the Policy if evidence satisfactory to Health Plan of the following conditions is furnished upon request:
 - (a) the child is not regularly employed on a full-time basis; and
 - (b) the child is a Full-time Student; and
 - (c) the child is primarily dependent upon the Subscriber for support and maintenance.
3. The term "Dependent" shall include a child who exceeds the age limitations stated in numbers 1 and 2 above if the child is incapable of self-support due to mental or physical handicap and if the child is chiefly dependent on the Subscriber for support and maintenance. Proof of such conditions is required and may be requested from time to time by Health Plan, as set forth in Section 3.2.

The Subscriber agrees to reimburse Health Plan for any Health Services provided to the child at a time when the child did not satisfy these conditions.

Section 3 "Termination of Coverage" is amended by replacing Sections 3.2 and 3.3 with the following Section 3.2, 3.3, and 3.4:

Section 3.2 Extension of Coverage for Handicapped Dependent Children. Coverage of an unmarried Enrolled Dependent child who is incapable of self-support because of mental or physical handicap will be continued beyond the specified limiting age, provided that (1) the child becomes so incapacitated prior to attainment of the limiting age, (2) the child is chiefly dependent upon the Subscriber for support and maintenance, (3) proof of such incapacity and dependency, satisfactory to Health Plan, is furnished to Health Plan within thirty-one (31) days of the child's attainment of the limiting age and (4) payment of any required Premium for the child is continued. Coverage will be continued so long as the child continues to be so incapacitated and dependent unless otherwise terminated in accordance with the terms of this Policy.

Before granting this extension, Health Plan may reasonably require that the child be examined at Health Plan's expense, by a Physician designated by Health Plan. Health Plan may require at reasonable intervals thereafter satisfactory proof of the child's continued incapacity and dependency, including medical examinations at Health Plan's expense. However, such proof will not be required more often than once a year after the two (2) year period following the child's attainment of the limiting age.

Section 3.3 Extension of Coverage for Confinement. If a Member is Confined on the date that Coverage under the Policy would otherwise terminate due to termination condition 3.1(a) (the entire Policy is terminated) and if the Policy is replaced by another group insurance plan. Coverage related to the Confinement (for facility charges only) shall continue until Confinement ends until maximum benefits under the Policy have been received or until the end of thirty (30) days, whichever occurs first.

Section 3..1 Payment and Reimbursement Upon Termination. Termination of the Policy shall not affect any request for reimbursement of Eligible Expenses for Health Services rendered prior to the effective date of termination when such request is furnished as required in Section 4 of this Certificate.

Louis B. Garcia
Executive Director

Definition of Emergency Care Amendment

The Policy is amended by revising the Certificate or Coverage as follows:

The definition of "Emergency" in "SECTION 1 DEFINITIONS" is replaced by the following:

"Emergency" -a life-threatening, disabling or serious Injury, Sickness or Mental Illness, including severe pain, which arises or worsens suddenly and which, if not treated immediately could reasonably be expected to result in loss of life or serious impairment to bodily functions or serious dysfunction of any bodily organ or part of a Member.

Louis G. Garcia
Executive Director

Principal Health Care of Iowa, Inc.
Amendment to the Certificate of Coverage

Form No: 002/20010

Purpose of Amendment

This document is an attachment to your Principal Health Care of Iowa, Inc. Certificate of Coverage. This amendment adds definitions for Actively at Work, Certificates of Creditable Coverage, Complaint, Creditable Coverage, Customer Service Representative, Enroll (Enrollment, Enrolled), Grievance, Late Enrollee, Statement of Health, We, Us or Our and You or Your(s) to Section 1 Definitions of Terms Used in this Certificate, replaces Section 2 Enrollment and Effective Date of Coverage, adds to Section 3 Termination of Coverage, Section 3.4 Certificates of Creditable Coverage, replaces Section 5 Complaint Procedures, and replaces Section 8 Continuation of Coverage and Conversion.

Section 1 Definitions of Terms Used in this Certificate: the definitions of Actively at Work, Certificates of Creditable Coverage, Complaint, Creditable Coverage, Customer Service Representative, Enroll (Enrollment, Enrolled), Grievance, Late Enrollee-, Open Enrollment Period, Statement of Health, We, Us or Our and You or Your(s) are as follows:

Actively at Work: An Enrollee performing all regular duties on a regularly scheduled work day:

- at the location where the duties are normally performed; and
- on a full-time basis.

An Eligible Person may be considered Actively at Work on a non-scheduled work day, but only if Actively at Work on the preceding scheduled work day. Additional consideration may be given on a case by case basis in order to comply with the provisions of the Family and Medical Leave Act of 1993.

Certificates of Creditable Coverage: The primary means by which individuals will prove prior credible coverage.

Complaint: A verbal or written expression of concern about our administrative procedures that may be resolved informally by a Customer Service Representative.

Creditable Coverage: Coverage under almost any type of medical plan provided in the United States. Pre-Existing limitation periods are reduced by prior Creditable Coverage.

Customer Service Representative: individual(s) employed by Health Plan with responsibilities including but not limited to providing Members with detailed answers to questions and concerns via telecommunications system and/or written communications in a timely manner.

Enroll (Enrollment, Enrolled): To apply for Covered Services under this Agreement and be accepted by the Health Plan.

Grievance: A written expression of concern about our administrative procedures, or a Complaint that has not been resolved to your satisfaction. Grievances require a written response by a Customer Service Representative, after a thorough investigation of the circumstances as related by you.

Late Enrollee: An individual whose enrollment in a plan is due to a late enrollment.

Open Enrollment Period: A period, established by the Employer, when eligible Employees are offered the option to choose or change Coverage.

Statement of Health: A signed statement from a Member verifying health status, that may be used by the Health Plan for case management purposes and to determine certain group eligibility and for rates.

We, Us or Our: Principal Health Care of Iowa, Inc.

You or Yours: The Member.

Section 2 Enrollment and Effective Date of Coverage is replaced by the following:

If an Eligible Person is Actively at Work and works or resides in the Service Area, the Eligible Person and Dependents may Enroll for Coverage as stated below, unless otherwise provided in the group master contract. The group _master contract shall take precedence when the eligibility and Enrollment provisions in this Agreement and the group master contract conflict.

Enrollment. If an Eligible Person and Dependents wish to Enroll during the Open Enrollment Period, or when the Eligible Person first becomes eligible, the Eligible Person must submit an enrollment form to Us. If We approve the enrollment form, Coverage begins on the date specified in the group master contract.

An Eligible Person and Dependents may Enroll alter the Open Enrollment Period if the Eligible Person becomes Actively at Work within thirty-one (31) days. The Eligible Person must submit to Us:

- an enrollment form;
- Statement(s) of Health; and
- payment for any additional Premium.

If Enrollment is approved and payment of the additional Premium is received, Coverage is effective on the date specified in the group master contract.

If an Eligible Person wishes to Enroll after the Open Enrollment Period and after he is Actively at Work for more than 31 days, he/she is considered a late entrant (provided no special Enrollment rules apply) and will be subject to the Plan rules on eligibility for Late Enrollees.

Rules of Eligibility for Late Enrollees. We will not accept Late Enrollees except at an Open Enrollment Period.

Special Enrollment period rules apply if an Eligible Person and/or Dependent(s) who is eligible but not enrolled in a plan wishes to enroll. The rules apply if:

- 1) The Eligible Person is covered under a group health plan (including COBRA coverage) at the time coverage is initially offered.
- 2) The Eligible Person states in writing that the other coverage is the reason for declining Enrollment
- 3) The other coverage that the Eligible Person had is either:
 - (a) COBRA Coverage that is exhausted, or
 - (b) The coverage is other health plan coverage and is terminated due to loss of eligibility or termination of employer contributions to the coverage and not due to failure to pay or termination for cause.
- 4) The Eligible Person and/or Dependent become eligible due to marriage, birth, adoption, or placement for adoption.

The Subscriber must submit to Us within thirty one (31) days:

- an enrollment form;
- appropriate legal papers; and
- payment for any additional Premium.

If Coverage for the Dependent(s) is approved and payment of the additional Premium is received, Coverage is effective on the date the change in Dependent(s) eligibility status occurred. If a Dependent(s) is not Enrolled within thirty-one (31) days of becoming eligible he/she is considered to be a late entrant, and is subject to the rules of eligibility for a late entrant

Newborn or Adopted Dependent Child. A newborn or adopted Dependent Child is Covered from the moment of birth or the date of adoption. If no additional Premium is required to Enroll a Dependent Child under family Coverage, We should be notified within 31 days, and a Primary Care Physician must be chosen. The addition of a Dependent Child may require the payment of an additional Premium to provide family Coverage. If so, We must receive notification and payment of the Premium within thirty-one (31) days after the date of birth or date of adoption. If not received, Coverage will terminate at the end of the thirty-one (31) day period.

Full-Time Student. A Full-Time Student, as defined in this Agreement, is Covered as a Dependent Child. Coverage ends the last' day of the month in which the Full-Time Student attains the limiting age or leaves school.

Members temporarily residing outside the Service Area due to full time school enrollment may seek selective Medically Necessary care outside the Service Area if they are enrolled in an institution that is sixty miles or more outside the Principal Health Care of Iowa Service Area. Such services include treatment of influenza; allergy injections; physical therapy due to an accident; and other conditions that result in sudden onset of the symptoms for which the Member cannot reasonably return home for treatment. All treatment outside the Service Area must be pre-authorized by Us.

Disabled Dependent. .An unmarried Dependent Child, who was a Member until attaining the limiting age, may continue Coverage under this Agreement if incapable of self-support because of mental retardation or a physical incapacity that began before attaining the limiting age. We reserve the right to request proof of disability periodically.

Section 3.4 Certificates of Creditable Coverage. is added as follows:

At the time Coverage terminates, each Covered individual is entitled to receive a certificate verifying the type of Coverage, the date of any applicable waiting periods, and the date any Creditable Coverage began and ended. Section 5. Complaint Procedures is replaced by the following:

We recognize that You may encounter situations where the performance of the Health Plan does not meet Your expectations. When this occurs, You may call the matter to Our attention. It is Our and/or Our Providers policy .and practice to consider all Complaints and Appeals promptly and fairly. Our address and phone number are:

Principal Health Care of Iowa, Inc.
4600 Westown Parkway
Suite 301
West Des Moines, Iowa 50266-1099

(515) 225-1234
or
(800) 257-4692

PRINCIPAL HEALTH CARE OF IOWA, INC.
ELIGIBILITY AMENDMENT TO
MEMBERSHIP HANDBOOK AND GROUP MEMBERSHIP AGREEMENT

ARTICLE 1 --PURPOSE OF AMENDMENT

This document is an attachment to the Membership Handbook and Group Membership Agreement (form - ' PHC-3001-IA-HM0-8/94. PHC-3201 -IA-POS-8/94 or MC-O 1 01 93-0A). It replaces the Maternity Care Section of the Covered Services and the Eligibility Section entirely and amends the definitions slated in Article 4 below.

ARTICLE 2 – MATERNITY AND NEWBORN CARE

Maternity care is covered before and during confinement. and during the post-partum period. Hospital services including delivery or birthing room are covered. Professional services (including operations and special procedures such as Caesarean Section) anesthesia injectables, sonography, and laboratory services are covered

A newborn Dependent Child is covered from the moment of birth. If no additional Premium is required to add the newborn Dependent Child, then the Subscriber should notify the Health Plan as soon as possible so that a Primary Care Physician may be selected and the appropriate Covered Services provided.

If payment of a Premium is required to provide coverage for a newborn Dependent Child, notification of birth and payment of the required Premium must be furnished to Us within thirty-one (31) days after the date of birth in order to have the coverage continue beyond the thirty-one (31) day period. If payment is not received, coverage will terminate at the end of the thirty-one (31) day period.

Covered Services for newborn Dependent Children shall consist of coverage of Injury or Illness including the Medically Necessary care and treatment of diagnosed congenital defects and birth abnormalities. This includes, but is not limited to, inpatient or outpatient medical and dental (orthodontic and oral surgery) treatment for birth defects known as cleft lip and cleft palate.

ARTICLE 3 ELIGIBILITY

3.1 WHEN COVERAGE BEGINS

Coverage begins on either the Effective Date or the Eligible Date unless otherwise provided in the Group Master Contract. The Group Master Contract shall take precedence when the eligibility provisions in this Agreement and the Group Master Contract conflict.

The Effective Date is the date that We and the Employer have agreed to begin coverage for those Members who enrolled during the Open Enrollment Period. The Eligible Date is the date a Group Enrollment Form is approved by Us for those Employees and Family Dependents who enrolled at least thirty-one (31) days after the Effective Date. Employees and Family Dependents who enroll within thirty-one (31) days after the effective date will

begin coverage on the Effective Date. Employees and Family Dependents who enroll thirty-one (31) days or more after the Effective Date will begin coverage on the Eligible Date.

3.2 ENROLLING ELIGIBLE EMPLOYEES AND FAMILY DEPENDENTS FOR COVERAGE

If an Employee works or resides in the Service Area, he or she and Family Dependents may enroll for coverage according to the eligibility and enrollment criteria below unless otherwise provided in the Group Master Contract. The Group Master Contract shall take precedence when the eligibility and enrollment provisions in this Agreement and the Group Master Contract conflict.

A. Employee

If an Employee wishes to enroll during the Open Enrollment Period then the Employee must submit a Group Enrollment Form to Us. The Employee's coverage begins on the

An Employee may enroll after the Effective Date if he or she was not Actively at Work on the Effective Date or within thirty-one (31) days after the Effective Date, but then became Actively at Work. In this case, the Employee must submit to Us a Group Enrollment Form and Evidence of Insurability and pay any additional Premium. If coverage for the Employee is approved and payment of the additional Premium is received, coverage is effective on the Eligible Date. If coverage is denied, the Employee must wait until the next Open Enrollment Period to enroll to the Health Plan.

B. Spouse.

If a Subscriber wishes to enroll a Spouse during the Open Enrollment Period then the Subscriber must submit a Group Enrollment Form to Us. The Spouse's coverage begins on the Effective Date if We approve the Group Enrollment Form.

If a Subscriber wishes to enroll a Spouse after the Effective Date, the Subscriber must submit to Us a Group Enrollment Form, appropriate legal papers and Evidence of Insurability, and pay any additional Premium. If coverage for the Spouse is approved and payment of the additional Premium is received, coverage is effective on the Eligible Date. If coverage is denied the Spouse must wait until the next Open Enrollment Period to enroll in the Health Plan.

An exception to the above criteria occurs if the Subscriber has just married the Spouse. In this case the Spouse is eligible for Covered Services on the date of marriage, provided the Subscriber submits a Group Enrollment Form to Us within thirty-one (31) days of the date of marriage. If the Subscriber enrolls the Spouse after thirty-one (31) days of the date of marriage, the Subscriber must submit to Us a Group Enrollment Form, appropriate legal papers and Evidence of Insurability, and pay any additional Premium. If coverage for the Spouse is approved, and payment of additional Premium is received, coverage begins on the Eligible Date. If coverage is denied, the Spouse must wait until the next Open Enrollment Period to enroll in the Health Plan.

C. Dependent Child

If a Subscriber wishes to enroll a Dependent Child during the Open Enrollment Period, the Subscriber must submit a Group Enrollment Form to Us. The Dependent Child's coverage begins on the Effective Date if We approve the Group Enrollment Form.

If a Subscriber wishes to enroll a Dependent Child after the Effective Date, the Subscriber must submit to Us a Group Enrollment Form, appropriate legal papers and Evidence of Insurability and pay any additional Premium if coverage is approved and payment of the additional Premium is received, coverage begins on the Eligible Date. If coverage is denied the Dependent Child must wait until the next Open Enrollment Period to enroll in the Health Plan. The last day of coverage for a Dependent Child is the last day of the month in which the Dependent Child attains the Limiting Age.

Exceptions to the above criteria are the newborn Dependent Child, adopted Dependent Child, Full-Time Student and Dependent Child acquired by marriage.

1) Newborn or Adopted Dependent Child.

A newborn or adopted Dependent Child is covered from the moment of birth or the Date of Adoption. If no additional Premium is required to add the newborn or adopted Dependent Child, then the Subscriber should notify the Health Plan as soon as possible so that a Primary Care Physician may be selected and the appropriate Covered Services provided.

If payment of a Premium is required to provide coverage for a newborn or adopted Dependent child notification of birth or adoption and payment of the required Premium must be furnished to Us within thirty-one (31) days after the date of birth or Date of Adoption in order to have the coverage continue beyond the thirty-one (31) day period. If payment is not received, coverage will terminate at the end of the thirty-one (31) day period.

2) Full-Time Student.

A Full-Time Student is covered if the Dependent Child claims status as a Full-Time Student:

- is under the Limiting Age;
- is enrolled in and attending full-time (twelve (12) credit hours per semester) a recognized course of study or training in a public or private secondary school, college, university, or licensed trade school; and
- provides a Registrar's letter of student status to Us. Full-Time Student status
- regularly scheduled school vacation periods:
- absence from classes in which enrolled, for up to four (4) months due to physical or mental disability (Note: this does not include absence from classes for personal reasons); and
- temporary residence outside the Service Area to attend school.

Coverage for a Full-Time Student ends the last day of the month in which the Full-Time Student attains the Limiting Age. or the last day of the month he or she leaves school for personal reasons.

3) Dependent Child Acquired by Marriage

If a Dependent Child is acquired by the Subscriber through marriage, the Dependent Child is eligible for Covered Services on the date of marriage, provided the Subscriber submits a Group Enrollment Form to Us within thirty-one (31) days of the date of marriage. If the Subscriber enrolls the Dependent Child after thirty-one (31) days of the date of marriage, the Subscriber must submit to Us a Group Enrollment Form, appropriate legal papers and Evidence of Insurability, and pay any additional Premium. If coverage for the Dependent Child is approved, and payment of additional Premium is received, coverage begins on the Eligible Date. If coverage is denied, the Dependent Child must wait until the next Open Enrollment Period to enroll in the Health Plan.

4) Disabled Dependent

An unmarried Dependent Child may continue coverage under this Agreement if he or she is incapable of self-support due to mental retardation or physical handicap prior to attaining the Limiting Age. We reserve the right to periodically request proof of disability.

ARTICLE 4 – DEFINITIONS

Date of Adoption: The earlier of:

- a judicial decree of adoption or
- the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent

Dependent Child(ren): An unmarried person who has not yet reached the Limiting Age (except in the case of Disabled Dependents), including:

- a natural child;
- a Disabled Dependent;
- a stepchild;
- a foster child;
- an adopted child, or child in the process of being adopted, from the Date of Adoption;
- a child for whom the Member has been granted legal custody;
- a child for whom the Subscriber has the legal obligation to provide coverage pursuant to court order or court-approved agreement; or
- a grandchild of the Subscriber or the Subscriber's Spouse who is in the court-ordered custody of the Subscriber or the Subscriber's Spouse.

A Dependent Child may not be denied coverage on the grounds that the Dependent Child:

- was born out of wedlock;
- is not claimed as a dependent on the Member's federal income tax return; or does not reside with the Member or in the Health Plan's Service Area.

Disabled Dependent(s): An unmarried Dependent Child who at the time of reaching the Limiting Age is incapable of self-support because of mental retardation or physical handicap that commenced prior to the Dependent Child's attaining the Limiting Age.

Limiting Age: Younger than nineteen (19) years old or a Full-Time Student younger than twenty-four (24) years old.

Exhibit 3
Principal Health Care of Iowa Primary Care
Summary of Plan Provisions

Plan Provisions	Principal Health Care of Iowa Primary Care
Deductible Single/Family	None
Coinsurance Percentage	Varies: see below
Out of Pocket limit Single/Family	\$750/\$1500 or 200% of annual premium, whichever is less, per contract year. All copayments and coinsurance go toward out-of-pocket limit.
Hospital Services	
Room & Board	100% if authorized. Semi-private basis, unless medically necessary to use private room.
Medical/Surgical/ICU	100%
Outpatient Surgery	100%
Emergency Room	\$50 copay or 50% of total bill, whichever is less, for ER visits to plan hospitals. \$50 copay or 50% of total bill, whichever is less, for ER visits to out-of-area providers.
Inpatient Mental/Health Substance Abuse	80% Maximum 30 days per member per 12 month period.
Outpatient Mental Health/Substance Abuse	\$15 copay per visit. Maximum 30 individual or 45 group visits per member per 12 month period
Physician Services	
Surgery	100%
Inpatient Visits	100%
Office Visits	\$5 copay per visit for primary care physician. \$10 copay per visits per referral specialty care physician.
Preventive Care	\$5 copay per visit for routine physicals. \$5 copay per visit for well child care (primary care physician)
Emergency Room	\$5 copay for primary care physician office ER visits
Mental Health/Substance Abuse Visits	100%. Maximum 30 days per member per 12 month period for inpatient physician care.
X-Ray & Lab	100%
Immunizations and Injections	\$5 copay when provided by a primary care physician.

	\$10 copay for allergy treatment when provided by referral specialty physician.
Vision/Hearing Exams	100% for optometrist and \$10 copay for ophthalmologist. Limit one exam per 12 months. \$5 copay per visit for hearing exams.
Physical, Speech, Occupational and Respiratory Therapy	\$10 copay per visit. Maximum treatment period of 62 consecutive calendar days per condition.
Chiropractor	\$10 copay per visit with approved referral.
Additional Services	
Prescription Drugs	\$5 copay or 25% per prescription, whichever, is higher, from plan pharmacies.
Durable Medical Equipment	80% if authorized by primary care physician. 100% if provided in lieu of hospital confinement.
Prosthetic Devices	80% if authorized by primary care physician.
Eyeglasses	Not covered except 20% copayment for first pair of glasses or contact lenses after cataract surgery provided under direction of primary care physician.
Hearing Aids	Not covered.
Ambulance	100% to nearest facility
Home Health Care	100% if authorized with referral
Dental	80% if authorized for accidental care only. Services must be provided within 6 months of the injury.